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► **Maternity benefits in ASEAN:
Progress and opportunities
for integrated approaches
across social protection
and health systems**

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Progress and opportunities
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► Abstract

Ensuring income security and access to healthcare without hardship during maternity are key elements of maternity protection and essential to support maternal and child health while ensuring that women can effectively engage in the labour force on par with their male counterparts. This impacts on employment, productivity and the health and well-being of women, their children and society more broadly. It is an essential contribution to the promotion of gender equality.

In this context, the right to universal social protection during maternity needs to be upheld and its profile must be raised as an essential public investment in the future and a core component of countries' economic, health and care policies. This report highlights the guidance provided by international social security standards related to social protection during maternity and explores the current situation and trends in ASEAN Member States.

Key words: maternity protection, social protection, maternity, maternal health, reproductive, maternal, neonatal and child health, social security, social health protection, maternity cash benefits, cash transfer.



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► Executive Summary

Ensuring access to income security and healthcare without hardship during maternity are key elements of maternity protection and essential to support maternal and child health while ensuring that women are able to effectively engage in the labour force on par with their male counterparts. This impacts on employment, productivity and the health and well-being of women, their children and society more broadly. It is an essential contribution to the promotion of gender equality.

In many ASEAN Member States, the health and well-being of pregnant women, new mothers and their children remains a concern. Some countries are at risk of failing to achieve Sustainable Development Goal (SDG) targets on maternal and child health. A range of studies point to the significant role of social determinants, such as unemployment and access to social protection, in driving these unequal health outcomes (Feng et al 2023).

This report provides an analysis of the range, coverage and level of social protection benefits which support income security and provide financial protection against healthcare costs during maternity in ASEAN Member States. In particular, the report highlights:

- Social protection benefits are only a part of the broader ILO framework for maternity protection, which includes a range of interdependent components, such as entitlements to maternity leave in the labour code, employment protection, occupational safety and health in the workplace and workplace breastfeeding policies.
- Social protection during maternity encompasses a range of benefits aiming at both access to healthcare without hardship and income security during pregnancy, birth and the period following birth. These two elements are complementary and the effectiveness of one is hampered if there are gaps in the other.
- Social protection benefits provided during maternity are tools that support a range of policies and are therefore cross-sectoral by nature. In particular, they directly link to the comprehensiveness and coherence of broader social protection systems, but also to broader health, social, care and employment policies.
- There are gaps in legal coverage of both cash benefits and social health protection, highlighting stark **inequities**, depending on labour force participation, status in employment, informal nature of employment, citizenship and residential status, and geographical location. This is true of both cash and healthcare benefits, but it is more pronounced when it comes to cash benefits.
- Some countries continue to rely on **employer liability** mechanisms for maternity cash benefits, whether in part or in full. These modalities may limit access to benefits or the adequacy of benefits where compliance is low, while also generating incentives for the discrimination against women of reproductive age in the labour market.
- The **adequacy** of provided benefits is also a concern:
 - Significant **differences in entitlements** between distinct categories of women prevail, especially between formal and public sector workers and self-employed workers, compared with those in informal employment and migrant workers. While some efforts are being made in certain contexts (including in Thailand) to promote greater coherence, promoting social justice and health equity calls for greater harmonization and reduced inequities in entitlements.
 - In a few contexts, maternity cash benefits are paid as **lump sums** (including for specific categories of the population), which do not afford adequate protection during maternity.
 - Data on the **benefit packages** of several social health protection mechanisms across ASEAN Member States are defined implicitly or not readily available, making it difficult to ascertain whether all the essential health services required during maternity are included and effectively provided, accessed

and used. Many countries continue to apply **co-payments** to access maternal, neonatal and child health services under health protection mechanisms.

- While some countries promote a level of **coherence** between maternity cash benefits and access to necessary healthcare services during maternity, including by providing for paid time off to attend antenatal care, this is not universally the case. Further reflection on alignment and coherence is required in several contexts.
- The lack of **sustainable and sufficient financing** for health and social protection in general, and for benefits and services geared at women and children in particular, remains a significant determinant of gaps in coverage and adequacy, which needs to be urgently addressed.
- **Disaggregated data** on the share of the population protected against the costs of accessing healthcare is urgently needed. This would inform a better understanding of the differences in access to Reproductive, Maternal, Newborn, and Child Health (RMNCH) benefits and services, depending on geography, age and migration status, among other characteristics. Data are also needed to track public expenditure on social protection during maternity.

With a view to bridging gaps in coverage and adequacy, while ensuring better integration of social protection benefits during maternity, the following recommendations are made:

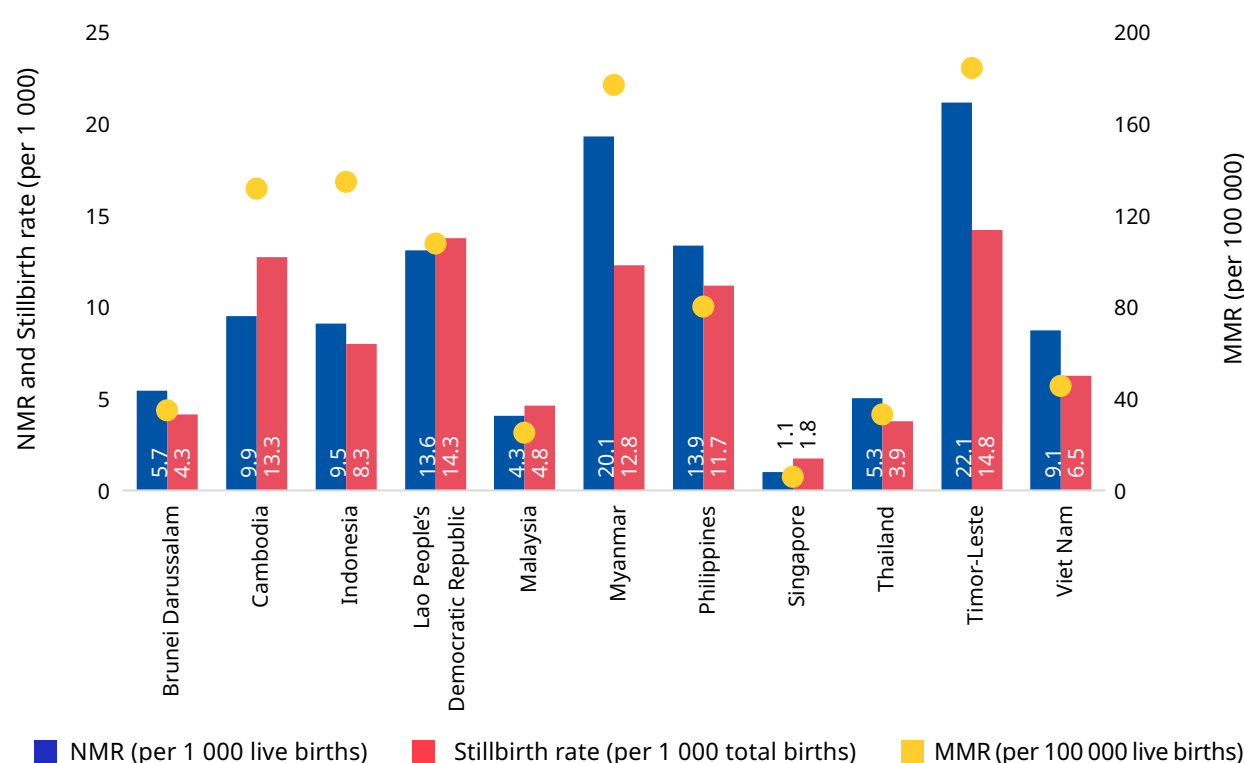
- It is essential to consider needs during maternity **holistically** rather than as separate component parts, in recognition of the diversity of vulnerabilities faced during this period. This requires governments to legislate, administer and finance maternity protection in a coherent manner to ensure that all pregnant and lactating women and newborns have access to the range of complementary support that is needed.
- Efforts to **extend coverage**, particularly to women in informal employment, the self-employed and migrant workers, must be redoubled to make progress towards universal social protection. This is essential to ensuring that pregnant and lactating women and their families are prevented from falling into poverty and vulnerability, and to guarantee their health and well-being. There are many positive examples from within the region of innovative approaches to extending coverage, including in relation to the financing and design of schemes, and their implementation modalities. The lessons from these examples could inform policy and action in contexts where systematic gaps persist.
- Achievements in relation to coverage must be combined with efforts to improve the **adequacy** of benefits provided, ensuring effective financial protection and adequate income support. Greater efforts to strengthen the coherence and harmonization of entitlements across schemes would also support efforts to promote equity among pregnant and lactating women and their families.
- To make progress in the areas noted above, it is essential to allocate adequate and sustainable **financing** for social protection during maternity. This requires evidence-based decision making, the prioritization of social protection and maternity within national policy agendas, and innovative approaches to resource mobilization. Complementary investments in the healthcare system and childcare policies are also essential to ensuring effective access to quality services and promoting coherence between policy areas.
- Cross-cutting progress would be facilitated through greater **exchange of knowledge** and experiences across the region. While substantive gaps persist across the region, there are also positive examples of innovations to adopt more holistic approaches to maternity that promote coherent and universal coverage and adequacy.

► 1 Introduction

Ensuring income security and access to healthcare without hardship during maternity are key elements needed to support maternal and child health while ensuring that women can effectively engage in the labour force on par with their male counterparts. This impacts on employment, productivity and the health and well-being of women, their children and society more broadly. It is an essential contribution to the promotion of gender equality.

In many ASEAN Member States, the health and well-being of pregnant women, new mothers and their children remains a concern. Some countries are at risk of failing to achieve SDG targets on maternal and child health (Figure 1). A range of studies point to the significant role of social determinants, such as unemployment and access to social protection, in driving these unequal health outcomes (Feng et al. 2023).

► **Figure 1: Maternal mortality ratio, neonatal mortality rate and stillbirth rate, by selected countries, latest available data**



Source: Based on data from the World Health Organization (WHO), 2024, Global Health Observatory; UN Inter-agency Group for Child Mortality Estimation (UN IGME), 2025.

In this context, the right to universal social protection during maternity needs to be upheld and its profile must be raised as an essential public investment in the future and a core component of countries' economic, health and care policies. Universal social protection refers to social protection systems that ensure everyone has access to comprehensive, adequate and sustainable protection over the life cycle, including during maternity, in line with ILO standards. Achieving universal social protection entails actions and measures to realize the human right to social security, with the objective of ensuring income security and access to healthcare without hardship for all. Universal social protection ensures access to essential services, including healthcare, which is crucial

for the prevention and reduction of poverty, inequalities and social exclusion, maintaining living standards and effectively sustaining incomes. In the context of covariate shocks and crises, it can respond effectively, enabling access to healthcare and stabilizing aggregate demand by supporting income security and business continuity. As an investment in human capabilities, decent work and inclusive economies, a universal social protection system bolsters the social contract (ILO, 2024a).

This report provides an analysis of the range, coverage and level of social protection benefits which support income security and provide financial protection against healthcare costs during maternity in ASEAN Member States. The analysis builds on the ILO conceptual framing of maternity protection with a focus on medical care and cash benefits during maternity (chapter 2). On this basis, the report provides a cross-comparative overview of the design and implementation of benefits, including their coverage, adequacy and financing (chapter 3), followed by an overview of identified examples in terms of their coordination and level of integration (chapter 4). The report concludes with recommendations on the way forward (chapter 5). It was developed through a mapping of each country's existing schemes and systems, through which key elements were summarized in dedicated country profiles, included in the report's annexes.

► 2 Understanding social protection during maternity

Key messages

- Social protection benefits are only a part of the broader ILO framework for maternity protection, which includes a range of interdependent components, such as entitlements to maternity leave in the labour code, employment protection, occupational safety and health in the workplace and workplace breastfeeding policies.
- Social protection during maternity encompasses a range of benefits aiming at both access to healthcare without hardship and income security during pregnancy, birth and the period following birth. These two elements are complementary and the effectiveness of one is hampered if there are gaps in the other.
- Social protection benefits provided during maternity are tools that support a range of policies and are therefore cross-sectoral by nature. In particular, they directly link to the comprehensiveness and coherence of broader social protection systems, but also to broader health, social, care and employment policies.

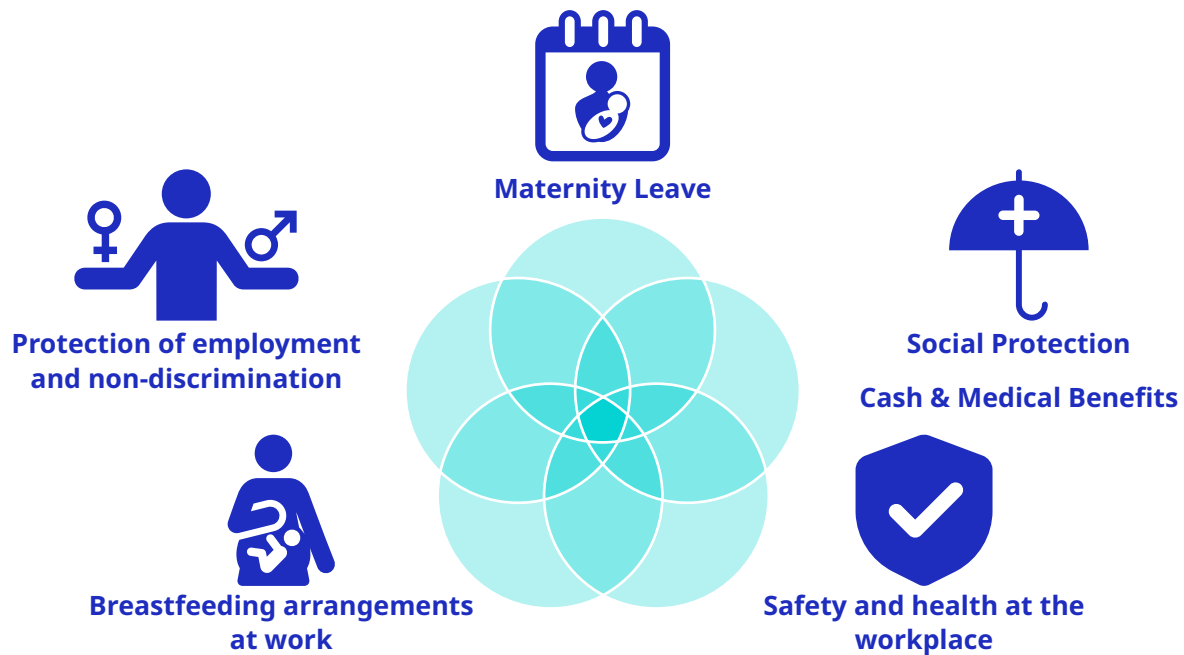
Maternity protection within ILO standards and policies

ILO framework for maternity protection

International labour standards (see box 1) offer a comprehensive definition of what maternity protection should include to protect women's ability to combine family and work responsibilities. The ILO framework for maternity protection encompasses social protection (income security and access to free maternal healthcare services), as well as the right to interrupt work activities to rest and recover around childbirth, and the protection of women's right to work and rights at work during maternity and beyond. The framework includes measures that prevent risks, protect pregnant women from unhealthy and unsafe working conditions and environments, safeguard their employment, protect them against discrimination and dismissal, and allow them to return to their jobs after maternity leave under conditions that take into account their specific circumstances and needs, including breastfeeding (Addati, Cattaneo, and Pozzan 2022) (see figure 2).

The Maternity Protection Convention, 2000 (No. 183), and the Maternity Protection Recommendation, 2000 (No. 191) inherently recognize that rights to social protection during maternity are interwoven with women's rights to work and at work. Social protection that aims to prevent poverty and promote well-being during maternity is significantly undermined where the protection of women's right to work and rights at work are not guaranteed. With respect to equality of opportunity for, and treatment of women and men, maternity protection takes into account the particular circumstances and needs of women, enabling them to enjoy their economic rights while raising their families. Maternity protection can help to counteract the so-called "motherhood penalty", namely the disadvantages mothers of young children face compared to fathers or women without children. Indeed, mothers are less likely to be employed, receive lower wages and are less likely to work in managerial or leadership positions than women without children, fathers and men without children.

► **Figure 2: Components of maternity protection in ILO standards**



Source: authors based on ILO Maternity Protection Resource Package.

► **Box 1: International standards relevant to maternity protection**

A woman's right to maternity protection is enshrined in the Universal Declaration of Human Rights (1948), which sets out the right to social security and special care and assistance for motherhood and childhood. The International Covenant on Economic, Social and Cultural Rights (1966) establishes the right of mothers to special protection during a reasonable period before and after childbirth, including prenatal and postnatal healthcare and paid leave or leave with adequate social security benefits. The Convention on the Elimination of All Forms of Discrimination against Women (1979) recommends that special measures be taken to ensure maternity protection, proclaimed as an essential right permeating all areas of the Convention.

Since ILO's adoption of the Maternity Protection Convention, 1919 (No. 3) in the same year of its establishment, a number of more progressive instruments have been adopted, in line with the steady increase in women's participation in the labour market in most countries worldwide. The Social Security (Minimum Standards) Convention, 1952 (No. 102), Part VIII, sets minimum standards regarding population coverage of maternity protection schemes, including cash benefits during maternity leave, to address the temporary suspension of earnings (see Annex 3, table A3.7). The Convention also defines the medical care that must be provided free of charge at all stages of maternity, to maintain, restore or improve women's health and their ability to work. Furthermore, it stipulates that free maternal healthcare must be available to women and the spouses of men covered by maternity protection schemes.

The Maternity Protection Convention, 2000 (No. 183), and its accompanying Recommendation (No. 191), provide detailed guidance for national policymaking and action aiming to ensure that women:

- are granted at least 14 weeks of maternity leave paid at a rate of at least two thirds of previous earnings (Convention No. 183) or up to 18 weeks at 100 per cent (Recommendation No. 191);

- ▶ are granted medical benefits for themselves and their child including prenatal, childbirth and postnatal care, as well as hospitalization care when necessary;
- ▶ have employment protection during pregnancy, maternity leave and the right to return to the same or an equivalent position;
- ▶ enjoy the right to one or more daily nursing breaks or a daily reduction of hours of work to breastfeed their children; and
- ▶ are not required to perform work which has been determined by the competent authority to be prejudicial to their health or that of their children.

In order to protect women's rights in the labour market and ensure that maternity does not constitute a source of discrimination by employers, ILO maternity protection standards specifically require that cash benefits be provided through schemes based on solidarity and risk-pooling, such as compulsory social insurance or public funds, while strictly circumscribing the potential liability of employers for the direct cost of benefits.

The Social Protection Floors Recommendation, 2012 (No. 202) calls for access to essential healthcare, including maternity care and basic income security, for people of working age who are unable to earn sufficient income owing to (among other factors) maternity. Cash benefits should be sufficient to allow women to live a life of dignity and without poverty. Maternal healthcare services should meet the criteria of availability, accessibility, acceptability and quality; they should be free and should not create hardship or increase the risk of poverty for those in need of healthcare. Maternity benefits should be granted to all residents of a country. Reinforcing the objective of achieving universal protection, the Transition from the Informal to the Formal Economy Recommendation, 2015 (No. 204), calls for the extension of maternity protection to all workers in the informal economy.

Source: ILO, 2024a.

Maternity leave

Maternity leave addresses the need of a person to take time away from work who is at the last stages of pregnancy, during the period right after giving birth, when recovering from delivery and bonding with the newborn, and if they encounter pregnancy complications that impede work. Maternity leave is separate from holiday entitlements and should be defined in labour laws. Each country defines instances in which there is a suspension of earnings during maternity leave – it is in such instances that social protection is needed to replace income during the maternity period. Countries may also define a period, if any, during which there is a legal obligation for employers to cover the salary of workers (employer liability).

It is essential to legally guarantee a maternity leave period and it is crucial to closely align the social protection system to avoid any period of suspension of income. In terms of duration, the latest ILO standards on maternity leave establish a duration of at least 14 weeks,¹ with the Maternity Protection Recommendation, 2000 (No. 191) proposing an increase to 18 weeks. This period should include at least six weeks of mandatory leave after childbirth to protect maternal health. In practice, over 120 countries now provide 14 weeks or more of maternity leave in line with ILO standards. In addition, 52 countries meet or exceed the ILO 18-week standard. However, in 64 countries the duration of maternity leave is still below 14 weeks (Addati, Cattaneo, and Pozzan 2022).

1 Conventions older than the Maternity Protection Convention, 2000 (No. 183) stipulate 12 weeks.

Paternity leave and parental leave

Adequate provision for paid paternity leave is an important corollary to maternity protection policies and contributes to a more equal sharing of family responsibilities. In 2021, 115 countries provide paternity leave. However, only one in ten potential fathers live in countries that provide at least ten days of paternity leave, and almost two-thirds of potential fathers (1.26 billion men) live in countries with no entitlements to paternity leave (Addati, Cattaneo, and Pozzan 2022). In sum, paternity leave tends to be short and can be either paid or unpaid, but social protection systems seldomly involve compensation of lost income related to paternity. In addition, take-up rates remain low, including in ASEAN and Asia Pacific region more broadly. Potential reasons for this, among other factors, include stereotypes of men as “breadwinners” and attitudes that overlook their roles as fathers and caregivers.

In addition to maternity and paternity leave and benefits, in line with the Workers with Family Responsibilities Convention, 1981 (No. 156) and its related Recommendation,² some countries have introduced parental leave that either parent can take after the period of paid maternity or paternity leave. As of 2021, 68 out of 185 countries have offered a statutory right to parental leave, 48 of them in Europe and Central Asia. While maternity leave is widespread, statutory, paid parental leave is less common, with only two out of ten potential parents covered globally, mostly in Europe and Central Asia.

Within the broader framework of maternity protection, social protection systems have an important role to play in ensuring that income security and access to free maternal healthcare are guaranteed.

The role of social protection systems: objectives, types and coverage dimensions of maternity benefits

Objectives

ILO standards recognize the need for social protection to respond to two complementary objectives in case of maternity:

- **Income replacement/income support.** This is needed for women at the last stages of pregnancy and during and after childbirth when they should be able to stop working to secure their own health and the health of their children. It is necessary to ensure that they can enjoy a minimum level of income during these periods to maintain a decent living standard (Razavi et al. 2024). A lack of income security during the final stages of pregnancy and after childbirth forces many women to either keep working into the very late stages of pregnancy or to return to work prematurely, thereby exposing themselves and their children to significant health risks (ILO 2024a). This risk is exacerbated when social health protection is not available and the cost of seeking care is paid out of pocket (ILO 2026b). Yet only around 36.4 per cent of women with newborns worldwide receive a maternity cash benefit, which leaves the majority (63.6 per cent) without income security shortly before and after giving birth (ILO 2024b). There are also significant and troubling regional variations: while coverage is just under 80 per cent in Europe and Central Asia, only 38.4 per cent of mothers of newborns in Asia and the Pacific are covered.
- **Financial protection when accessing maternal healthcare services.** Effective access to appropriate prenatal and postnatal healthcare services without hardship for pregnant women and mothers with newborns is an essential component of both maternity protection and social health protection. Making such services free lifts the financial barriers of access to healthcare that may be particularly pronounced for women. This is important to improve maternal and child health and reduce maternal and child mortality, while reaching universal health coverage and achieving gender equality (SDG targets 3.1, 3.2,

² Workers with Family Responsibilities Recommendation, 1981 (No. 165).

3.8 and 5.6). The global maternal mortality ratio declined by 34 per cent between the year 2000 to 2020. Yet, in 2020, 287,000 women (223 deaths per 100,000 live births) globally died from a maternal cause, equivalent to almost 800 maternal deaths every day, or approximately one every two minutes. As many as 95 per cent of all maternal deaths occurred in low and lower middle-income countries (WHO, UNICEF, and UNFPA 2023).

These two mutually reinforcing objectives of income support and free healthcare during maternity are intrinsically linked, including at the household level, calling for integrated design and coordinated delivery of related social protection benefits and programmes. This integration is key given that many socio-economic factors determine the health outcomes of pregnant women. Climate change, for example, is expected to increase maternal and newborn morbidity and mortality due an increased frequency of extreme weather events (Segal and Guidice 2022; Dodzi Nyadanu et al. 2024).

Together, they are intermediate objectives to effectively prevent poverty and hardship during maternity:

- Together, they support women's access to necessary resources to meet their basic needs and those of their children (Razavi et al. 2024). Income is fungible within the household, and therefore out-of-pocket healthcare expenses have a direct impact on available income for other necessities (such as housing, nutrition and transportation, for example). Conversely, insufficient income to meet basic shelter and food requirements will create an incentive to forgo or delay care.
- Together, they address some of the key social determinants of health equity for maternal health outcomes and promote well-being and effective access to healthcare, while ensuring women are covered against direct and indirect costs of accessing healthcare (Cookson et al. 2023). The health dividends can be significant. There is a wide range of literature documenting the impact of social protection benefits, and particularly coordinated packages providing cash and care, on maternal health outcomes. In particular, a range of studies have shown the positive impacts of creating an enabling environment for breastfeeding, supporting maternal mental health in the perinatal period, and supporting deliveries assisted by healthcare professionals (Angeles et al. 2024; Perera et al. 2022). Social protection programmes combining income support and access to free maternal services can contribute to redressing some significant inequalities in access to healthcare services in rural areas, and among particularly vulnerable groups that experience intersectional deprivations and/or discrimination.

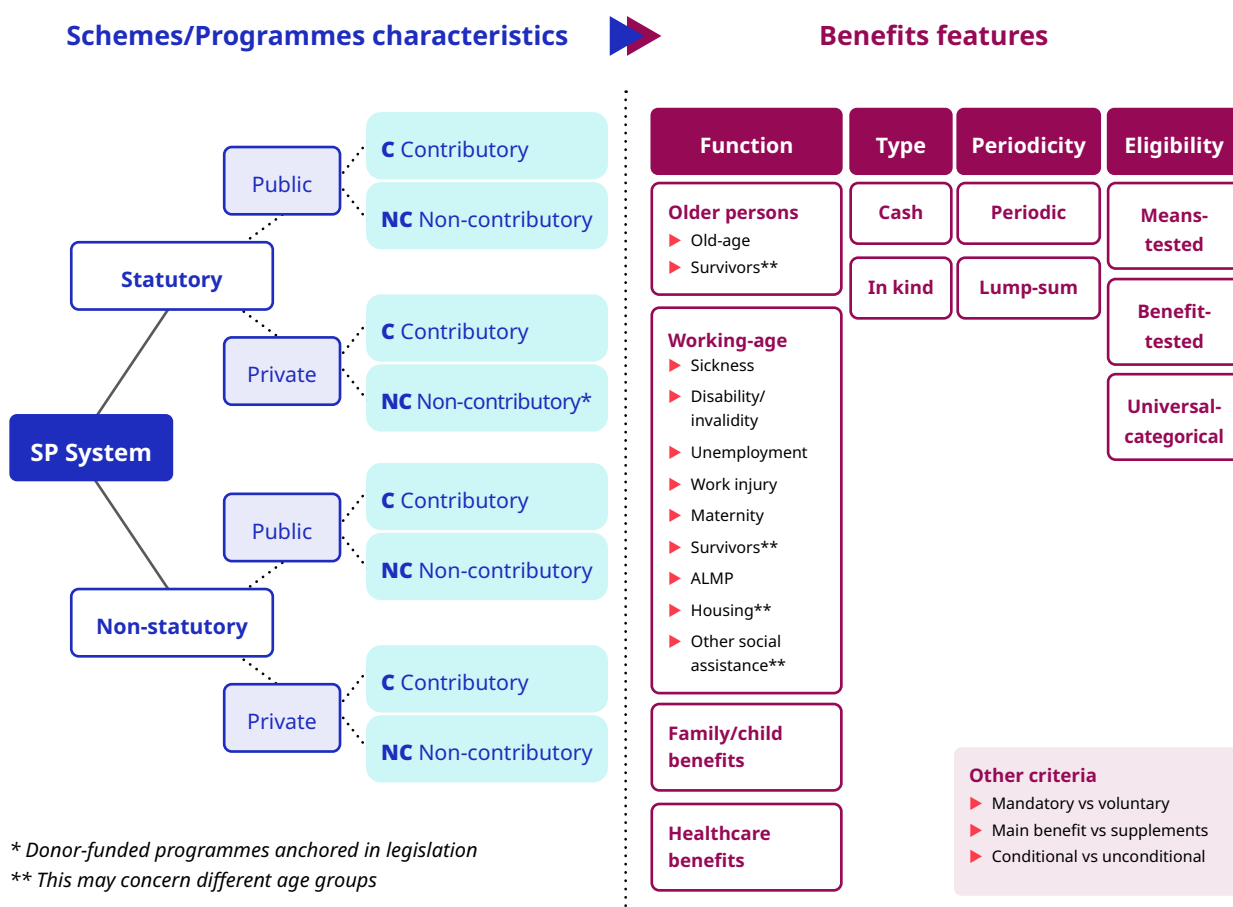
Financing

Convention No. 183 recommends that countries introduce collectively financed maternity benefits (social insurance, social assistance/tax-financed or a mix of both) rather than relying on employer liability mechanisms. This improves equality of treatment for women and men in the labour market. It does so by shifting the burden of bearing the costs of maternity benefits from the individual employer to the collective, countering discrimination against women of childbearing age in hiring and in employment, and reducing the risk of non-payment of due compensation by the employer (ILO 2024b; Addati 2015). Such reforms can also facilitate the coverage of women with low contributory capacities and interrupted employment histories, including those in part-time or temporary employment, and those in self-employment (Razavi et al. 2024).

Types of benefits

There are many types of entitlements and institutional arrangements that countries have created to respond to the two interlinked objectives mentioned above. This sub-section provides a rapid typology of such schemes and their institutional set-up. This typology is guided by the ILO framework for classifying social protection schemes (figure 3), which provides an overview of the range of possible social protection benefits that exist worldwide.³

3 More definitions can be found in the glossary in the Annexes of ILO's World Social Protection Report 2024-2026, available at: https://www.ilo.org/sites/default/files/2024-09/WSPR_2024_EN_WEB_1.pdf

► **Figure 3. Overview of social protection schemes and benefits characteristics and features**

SP = social protection, ALMP = active labour market policies.

Source: (ILO 2024a).

Benefits in cash

Income replacement through contributory mechanisms during maternity

Contributory schemes are schemes in which contributions made by protected persons (actual or potential beneficiaries) directly determine entitlement to benefits (acquired rights). In the case of maternity cash benefits, the most common form is a statutory social insurance scheme, which usually covers workers in formal wage employment and, in some countries, the self-employed. Through such schemes, workers, employers and sometimes governments make monthly contributions proportional to income, which are pooled in a fund and used to pay for maternity benefits when one covered person is pregnant and delivers. Contributory schemes can be wholly financed through contributions but are often partly financed from taxation or other sources –such as a subsidy to cover the deficit, a general subsidy replacing contributions altogether, or through subsidies directed specifically at certain groups of contributors or beneficiaries. The benefits of such schemes are usually a percentage of past earnings, which can be calculated to ensure that adequate standards of living can be maintained when workers on maternity leave have their wage or income suspended. Being enrolled in such a scheme can also provide eligibility for additional benefits, including birth grants and, in some cases, child grants that can start at the last stages of pregnancy.

Income support through non-contributory schemes during maternity

Non-contributory schemes are schemes that do not require a direct contribution from beneficiaries or their employers as a condition for entitlement to receive maternity benefits. Such maternity cash benefits schemes are financed through taxes or other state revenues, or in certain cases, through external grants or loans. The objective of these types of schemes is to support income security, but entitlements are not calculated as a percentage of past earnings, which are not known. As such, they are not strictly a form income replacement and do not necessarily aim to sustain the beneficiary's standards of living. Non-contributory schemes encompass a broad range of designs, including:

- **Universal maternity benefits for all residents.** These types of non-contributory schemes usually define a monthly sum or a lump sum that is meant to be sufficient to support income security during the maternity period. This is provided to all pregnant women/women giving birth for a determined period in the defined territory.
- **Means-tested schemes for maternity.** These types of non-contributory schemes also usually define a monthly sum or a lump sum intended to be sufficient to support income security during the maternity period. In contrast to universal schemes, this is provided to pregnant women/women giving birth under a certain income threshold or under the poverty line in the defined territory for a determined period. In some countries, proxy means tests are used, through which eligibility is determined without actually assessing income or assets; rather, eligibility is determined on the basis of other household characteristics (proxies such as household composition, housing characteristics, productive assets or level of education of household members), which are deemed to be more easily observable.
- **General cash transfers directed at households to support them to meet basic needs.** Cash transfers are non-contributory schemes or programmes providing cash benefits to individuals or households, usually financed through taxation, other government revenues, or external grants or loans. They are usually designed specifically for poverty reduction and tend not to target a specific life contingency, such as maternity, but this can be included in the criteria used to assess eligibility. Cash transfer programmes may or may not include a means test. Programmes that provide cash to families subject to the condition that they fulfil specific behavioural requirements are referred to as conditional cash transfer programmes. For example, beneficiaries may be required to ensure that their children attend school regularly, or to use basic preventive nutrition and healthcare services.
- **Birth grants.** Birth grants are amounts paid upon birth with the objective of supporting parents to offset some of the initial expenses related to the arrival of a newborn. They are usually lump sums that are claimed by parents after the birth and delivered upon proof of birth (in some countries they are used to incentivize birth registration). Birth grants can be a part of both contributory and non-contributory schemes.
- **Child grants and family benefits.** Non-contributory benefits to support families with children can be universal or means-tested and, in some cases, they can start at the last stages of pregnancy, and therefore be accessible during the perinatal period.
- **Paid parental leave benefits.** Parental leave designates time off work that parents can take in order to attend to the care of their children. In many countries this can be taken by either parent (or both), for periods varying in length and usually within the first years of life of the child. Parental leave is not always paid, and when it is this is usually through social protection policies – as this leave can last for extended periods, the liability is usually not placed on the employer (ILO, 2024b). The benefit levels and length of entitlement to such programmes vary widely across countries and they are most prevalent in Europe and Central Asia (Addati, Cattaneo and Pozzan 2022).

Healthcare benefits

A range of social health protection schemes or programmes aim at offsetting the costs of maternal healthcare services. They can be part of broader national health services or national health insurance schemes which also cover a range of other healthcare needs, or they can be dedicated programmes for maternal and child health.

Contributory and non-contributory schemes for general healthcare needs

The scheme design and institutional set-up of social health protection entitlements vary widely across countries, and it is common for a mix of schemes and programmes to be used by countries to reach universal health coverage. Below is a schematic overview of the different types of schemes (Bergthaller and Tessier 2025; ILO 2024b, 2021a).

Social health protection can be the mandate of:

- A national health service, whereby services are financed and provided for free or with minimal user fees directly by the Ministry of Health;
- A national/social health insurance scheme, whereby an autonomous institution pools revenues from social security contributions and government transfers, and is in charge of purchasing healthcare services on behalf of the population; or
- A mix of these arrangements, with a wide array of options for centralization/decentralization, and concentration/fragmentation of programmes.

In practice the two first options are rarely encountered in their “pure form”, and mixed arrangements are prevalent. Various regional reviews of financing and institutional arrangements for social health protection have shown that these elements are poor predictors of outcome; rather, decisive factors are respect of core principles in line with ILO standards, political will and financial commitments (ILO 2021a). To extend social health protection, countries have adopted different types of measures, including (typology taken from (Bergthaller and Tessier 2025)):

► **Universal approaches:**

- National health services which are free at the point of care in public facilities. This is the case, for instance, in Malaysia and Brunei.
- National Health Insurance combining contributory and non-contributory entry points for different categories of populations. For example, Indonesia, the Philippines and Viet Nam have adopted such a strategy. In some countries, for example in Thailand, this is achieved through various schemes managed by different institutions for different population groups.
- Mandatory private health insurance for the entire resident population with non-contributory entry points for vulnerable populations. This exists in only a small number of countries globally,

► **Categorical and targeted approaches:**

- User fee waivers/exemptions or non-contributory health insurance for specific categories of the population. For instance, in India a scheme has been created to specifically cover people below the poverty line.
- User fee waivers or vouchers for specific health interventions. For instance, in a number of countries, such mechanisms have been put in place for tuberculosis, malaria or HIV prevention, diagnosis and/or care.
- Dedicated contributory social health insurance schemes are in place for specific groups, such as civil servants or private sector workers (as in Cambodia or Myanmar).
- In some countries, subsidies for private health insurance are available for specific vulnerable groups (for example in Switzerland and the Netherlands).
- Many countries have adopted a mix of targeted approaches, with varying degrees of coherence and articulation, often creating some gaps (ILO 2021a, 2024b, 2026a).

Regardless of the type of scheme, ILO standards underline the need for social health protection schemes to include maternity care free of charge, including as part of social protection floors⁴ and within minimum social security standards⁵ (ILO C102) (ILO 2020). However, some countries implement these provisions through dedicated schemes that are separate from those related to general healthcare needs. This decision can be motivated by the specific nature of the entitlements, but among countries that have made this choice, it is often because their social health protection schemes for general health needs are still under development, with significant gaps.

Specific programmes for maternal and child health

- **User fee waivers for prenatal and postnatal care and delivery in public facilities.** User fee waivers are programmes that offset the cost of specific health interventions related to pregnancy, delivery and newborn care. They are usually implemented in public facilities. The financing mechanisms of such programmes vary – sometimes the facilities receive financing to compensate for the lost user fees, and sometimes they need to rely on their pre-existing budget, which largely influences the success of such programmes. User fee waivers can be universal for all women, or they can be means-tested or target specific regions or vulnerable groups. They can be comprehensive, including all services for pregnant women and newborns, and sometimes also all primary healthcare services. In contrast they can also only cover specific maternal health services, such as antenatal care, facility-based delivery, caesarean section or emergency obstetric care (Hatt et al. 2013).
- **Voucher schemes for maternal (and sometimes child) health.** Vouchers are distributed to the target population, which can either encompass all pregnant women, or be limited to the poor, specific vulnerable groups, specific locations or certain types of facilities, such as rural or public. Beneficiaries exchange the vouchers for free, or reduced-cost packages of services. Such services can include a range of interventions – sometimes only medical services are included (including prenatal care, facility-based delivery, postnatal care), whereas in some cases additional services are available (such as transportation allowance or nutrition support). These types of schemes are often used in resource-poor settings where institutional delivery rates are low. A number of countries in the Asia-Pacific region, particularly in South Asia, use such voucher schemes (Ahmed and Khan 2011; Sultana et al 2023; Hunter and Murray 2017; Jehan et al 2021).
- **Other specific social protection programmes for maternal health.** In some countries, specific social health protection programmes have been developed. For example, in Kenya the Linda Mama programme provided universal coverage for maternal health, accessible to all pregnant women in the country upon registration, which could be done directly on their phones. In this case, the national health insurance fund would receive a contribution from the government general budget for each woman covered and reimburse the health facilities accordingly for a comprehensive package of maternal health services (ILO and NHIF 2023).

Population coverage

Universal social protection means that all pregnant women and women giving birth should have access to adequate and comprehensive maternity benefits that secure both income security and access to related health services without hardship. This entails including provisions for such entitlements in the legal framework. It also requires that intended beneficiaries are aware of their legal entitlements, as well as the modalities to avail them in practice. Key elements that affect access to maternity benefits include:

- **Broad risk pooling.** While the diversity of mechanisms and types of schemes that can be used to guarantee social protection during maternity can be wide, systems should be based on broad risk

4 See Social Protection Floors Recommendation, 2012 (No. 202).

5 See Social Security (Minimum Standards) Convention, 1952 (No. 102).

pooling and solidarity in financing (Addati 2015; ILO 2020, 2016). Convention No. 183 recommends that countries introduce collectively financed maternity benefits (social insurance or tax-financed) rather than relying on employer liability mechanisms. This improves equality of treatment for women and men in the labour market because it shifts the burden of bearing the costs of maternity benefits from the individual employer to the collective, countering discrimination against women of childbearing age in hiring and in employment, while reducing the risk of non-payment of due compensation by the employer. Such reforms can also facilitate the coverage of women with low contributory capacities and interrupted employment histories, including those in part-time or temporary employment, and those in self-employment. ILO standards promote broad risk pooling, meaning that countries should aim at extending coverage while avoiding overly fragmented systems, which tend to be less financially sustainable and more difficult for the population to navigate.

- **Design of eligibility criteria.** It is also worth noting that the definition of the contingency itself can vary in terms of inclusivity of scope: some schemes link eligibility to pregnancy, and others to childbirth, while some provisions also include miscarriages, abortions and still births, as well as situations of adoption, for instance (Addati, Cattaneo and Pozzan 2022; ILO 2024b).
- **Administrative processes.** Heavy administrative processes for registration, access to benefits and access to healthcare services affect the ability and willingness of intended beneficiaries to effectively access their entitlements. Administrative processes should be designed in a way that lightens the burden on the beneficiary and that fosters effective access and use (ILO 2021a, 2021b).

Adequacy

ILO standards place emphasis on the definition of minimum levels of protection that guarantee not only coverage but also adequacy of the benefits received. Adequacy encompasses a range of dimensions when it comes to both income security and access to healthcare services.

Benefits provided in cash to replace or support income security during maternity

Benefit level

According to international standards, governments are ultimately responsible for providing income security for expecting women, at least to the extent that “the woman can maintain herself and her child in proper conditions of health and with a suitable standard of living” (Convention No. 183). Adequate benefit levels are nationally defined and “may correspond to the monetary value of a set of necessary goods and services, national poverty lines, income thresholds for social assistance or other comparable thresholds established by national law or practice, and may take into account regional differences” (Recommendation No. 202). When possible and as reflected in higher level standards, the objective is not only preventing poverty but rather being able to maintain an adequate standard of living despite income loss around the time of delivery. International labour standards therefore define minimum benefit levels as a share of previous earnings (ILO 2024a). These levels are set at a minimum of 45 per cent in Convention No. 102 and two thirds in Convention No. 183.

Benefit duration

International standards require a minimum duration of maternity cash benefits, which should match the labour legislation provision on maternity leave, protecting women from having to work too long into their pregnancy or return to work too fast, before they are fully recovered (ILO 2024a). The minimum duration is set at 12 weeks in Convention No. 102 and 14 weeks in Convention No. 183, which is the most up-to-date international standard for maternity protection.

Healthcare benefits

To be considered adequate by ILO standards, healthcare benefits for maternity need to meet the following criteria:

- The benefit package (the range of health interventions and services included) needs to respond comprehensively to the needs of women and their children during pregnancy, delivery and post-delivery periods.
- The services should be made accessible without co-payments or cost-sharing for the beneficiary.
- The network of service providers where the benefit package can be availed should meet the criteria of availability, accessibility, acceptability and quality.

Package of services

ILO standards underline the need to define the package of health interventions that compose maternal care at the national level, which should be consistent with national practice as well as minimum international standards and good practices, including recognized guidelines. In terms of minimum standards, Convention No. 183 provides that women should be granted medical benefits for themselves and their child, including prenatal, childbirth and postnatal care, as well as hospitalization care when necessary. Recommendation No. 191 additionally notes in the preamble that, “to the extent possible, the medical benefits should include:

- (a) care given in a doctor’s office, at home or in a hospital or other medical establishment by a general practitioner or a specialist;
- (b) maternity care given by a qualified midwife or by another maternity service at home or in a hospital or other medical establishment;
- (c) maintenance in a hospital or other medical establishment;
- (d) any necessary pharmaceutical and medical supplies, examinations and tests prescribed by a medical practitioner or other qualified person; and
- (e) dental and surgical care.”

While the packages of benefits considered to be part of maternity care can differ from country to country, in addition to the minimum standards underlined in ILO standards, guidelines have also been developed under the framework of the World Health Organization (WHO 2016, 2022). In line with this, maternity care is included in the Reproductive, Maternal, Newborn, and Child Health (RMNCH) framework, which is holistic and follows the continuum-of-care. It focuses on health services from pre-pregnancy through adolescence, specifically covering reproductive health, pregnancy, childbirth, the first 28 days of life (newborn), and children up to the age of five (Black et al. 2016). The framework also includes reproductive health, providing important global guidance on sexual and reproductive health services. According to the WHO, sexual and reproductive health encompasses a broad range of services, including access to contraception, fertility and infertility care, maternal and perinatal health, prevention and treatment of sexually transmitted infections (STIs), protection from sexual and gender-based violence, and education on safe and healthy relationships. This connects directly with the provisions of the Violence and Harassment Convention, 2019 (No. 190).

Financial protection

ILO standards stipulate that maternity care should not be subject to cost-sharing. This is rooted in three important findings from international practice (Frota et al. 20:

- Timely maternity care, accessed at early stages and without delay, is an efficient and highly impactful investment in terms of health outcomes. Prenatal visits and surveillance have yielded significant results in reducing complications and associated costs. By meeting women’s health needs without delay, health systems can avoid having to provide at least some of the more intensive (and more expensive) care at a

later stage. Postpartum care ensures prompt recovery, as well as early identification and management of problems, contributing to health promotion, including infant immunization and advice on breastfeeding. This in turn facilitates the full recovery of women's capacity to work, complemented by maternity benefits during maternity leave.

- The benefits of investing in maternal health protection, for the health system and beyond, are significant compared to the costs. The probability of using the services is generally limited to a small number of events during a woman's lifetime, for a limited period. This limits the cost of maternal health packages per individual compared to compensation offered in the case of other social risks (sickness, injury or old age, for example). Furthermore, maternal and child health interventions are shown to be particularly cost-effective (Memirie et al. 2019).
- Ensuring the highest level of financial protection is crucial to improve effective access to maternity care for all. In this respect, the ILO minimum standards recommend that maternal care is offered at no charge for women. It is important to keep in mind that women may face greater challenges than men when having to make payments upfront to health facilities. They also may not have the same decision-making power regarding resource allocation in the household, which can further weaken their financial capacity.

Network of service providers

To translate into effective access, guarantees for free maternity care need to be available in a network of service providers that women can effectively access close to home when needed, which must follow an adequate continuum of care. It is critical to ensure that this network of healthcare facilities and providers meet the criteria of availability, accessibility, acceptability and quality (AAAQ). These dimensions are complex to realize and are closely related to sufficient investments made in service delivery systems, including in the training and retention of a qualified health and care workforce. In particular, the availability of midwives and healthcare personnel with knowledge and technical skills on sexual, reproductive, maternal and child health remains the backbone of systems that meet the AAAQ criteria⁸. Securing decent work for these health workers and valuing specializations in sexual, reproductive, maternal and child health in career paths are key elements of such strategies.

It is important to recognize that the above-mentioned benefits are only one piece of the puzzle, and that needs during maternity/infancy are multidimensional, which calls for complementarity and integration both within national social protection systems and with other policies. This will be explored in the following sections.

Complementarity between maternity benefits and the wider social protection system

While this report focuses on social protection during maternity, these benefits must be considered within a wider life cycle approach that promotes coherence and is user-centric. Indeed, the needs of a mother and child during maternity and the first months of life are not isolated but are intrinsically linked to health and income security throughout the life cycle.

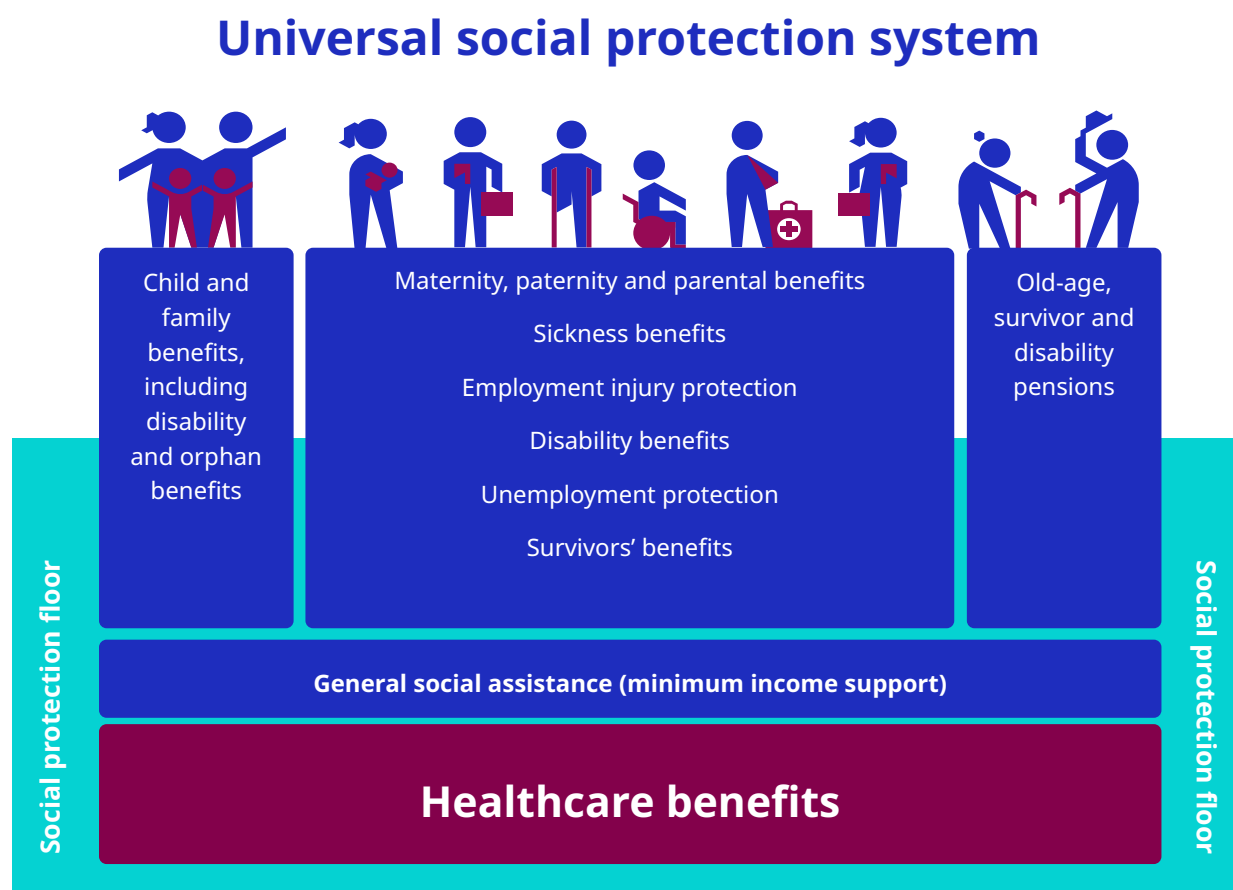
Universal social protection refers to social protection systems that ensure everyone has access to comprehensive, adequate and sustainable protection over the life cycle, in line with ILO standards. Achieving universal social protection entails actions and measures to realize the human right to social security by progressively building and maintaining nationally appropriate social protection systems. Rights-based social protection systems, encompassing social protection floors and higher levels of protection, guarantee that the rights and obligations of all parties concerned – workers, employers, governments and state institutions – are anchored in law and duly observed to ensure well-being and a dignified life. The State has the primary responsibility for establishing the legal and administrative architecture and sustainable financing of social security, and is the ultimate guarantor

⁸ See Nursing Personnel Convention 1977 (No 149) and its accompanying Recommendation.

of its proper administration and good governance. Universal social protection is crucial for the prevention and reduction of poverty, inequalities and social exclusion, effectively maintaining workers' incomes and living standards. As an investment in human capabilities, decent work and inclusive economies, a universal social protection system bolsters the social contract, ensuring the willingness of everyone to pay taxes and make social contributions, thereby sustaining the system and fostering social cohesion (ILO 2024a).

International social security standards provide a robust foundation for integrated social protection systems. In particular, the Social Protection Floors Recommendation, 2012 (No. 202) establishes that “coherence across institutions responsible for the delivery of social protection” is a core principle underpinning national social protection floors. More widely, these frameworks advocate for a life-cycle approach that ensures continuous coverage across all stages of life, moving beyond fragmented support (see figure 4). Furthermore, they provide a roadmap for coherence across the various branches of social security by emphasizing the necessity of consistency across legal and institutional frameworks, collective financing, and broad risk pooling to ensure solidarity.

► **Figure 4: Universal social protection systems**



Fragmentation across the social protection system can occur across a range of dimensions that create significant bottlenecks that impede effective coverage and access. For example, *fragmented legal and regulatory frameworks* (including where different benefits are governed by different laws and regulations) can lead to coverage gaps or inconsistencies, or a lack of clarity over rights and entitlements. In turn, fragmentation in *financing* may similarly result in gaps or inconsistencies in coverage, while also undermining the system's objectives of promoting solidarity and redistribution. Finally, where the *administration* of different schemes is implemented independently (institutional fragmentation), with disparate processes to register or claim benefits, these processes may generate administrative barriers to coverage and undermine uptake of rights and entitlements, while also generating operational inefficiencies.

While coherence is required across the social protection system, the importance of alignment between maternity benefits and family benefits, sickness benefits, long-term benefits, and within social health protection systems in particular, is highlighted below.

Child and family benefits

Benefits guaranteed during maternity and those afforded to families with children (such as family benefits) are highly complementary, owing to their shared objective of supporting families with children to meet their basic needs, avoid child poverty and contribute to early childhood development, child welfare and education attainment. There needs to be a continuum between maternity and child benefits, as both support families to access necessary goods and services during the first 1,000 days of life, which are foundational for a child's mental and physical development. Maternity benefits provide income support during the last few months of pregnancy, childbirth and the period following childbirth, while child benefits should take over after such periods to guarantee financial support during the child's first years of life at minimum. This is crucial to supporting families to meet their child's nutritional and educational needs, with strong impacts on their health and well-being in the long term (see chapter 4 in (ILO 2024a) and (ILO and UNICEF 2023)). Coherence in coverage, duration and eligibility for maternity benefits and benefits granted to families with children are crucial.

In certain contexts, social protection programmes are designed to provide support to both mothers and children for a period that covers pregnancy through to the early years of a child's life – often covering the first 1,000 days. This is the case for the Mother and Child Benefit Programme, for example, implemented in Bangladesh since 2019. The programme provides monthly cash benefits to pregnant women and mothers of children up to the age of four years (ILO and UNICEF 2023). Myanmar adopted a similar approach when it adopted its first national social protection strategy in 2014 (Tessier 2015). While maternity and child benefits may be administered as separate guarantees, there are also opportunities for administrative linkages which could enable families who are eligible for both benefits to seamlessly transition from one entitlement to the other, effectively reducing potential administrative hurdles in accessing benefits. The alignment of entitlements, eligibility and access procedures between these two types of cash benefits, combined with access to RMNCH services without hardship, is essential to effectively improving child health and well-being, particularly considering that the immune system is largely built during the first years of life (ILO and UNICEF 2023).

Healthcare benefits along the life cycle

Pregnancy is not an isolated medical event but rather represents one chapter in a woman's health history over the life course. Health during pregnancy is intrinsically linked to overall health status and the cumulative impact of prior access to healthcare or lack thereof (Yang et al. 2025). In particular, adverse birth outcomes have been associated with socio-economic difficulties that precede pregnancy, such as low income, substandard housing conditions and poor nutritional status; previous obstetric complications and maternal comorbidities such as hypertension or diabetes and an absence or underutilization of prenatal care have also been found to impact birth outcomes (Yang et al. 2025; Abate et al. 2025; Amjad et al. 2019). Conversely, obstetric complications without adequate access to healthcare can have long-term physiological implications for the future, increasing a woman's risk of chronic medical conditions later in life (Yang et al. 2025; Abate et al. 2025; Amjad et al. 2019).

Integration of services through pregnancy, infancy, and into childhood is also essential to enhancing a child's health and developmental outcomes.

These interdependencies call for coherence and continuity within the various social health protection mechanisms established to guarantee maternity care without hardship, and their alignment with broader access to healthcare along the life cycle (ILO 2026b). When sexual and reproductive healthcare, maternal care, pediatric services, and wider health services are siloed, the resulting gaps often lead to adverse health outcomes and financial hardship for families, and can represent barriers to effective access to the continuum of care. To mitigate these risks, social health protection schemes covering a comprehensive benefits package that addresses health needs throughout the life cycle – rather than fragmented or vertical programmes – should be promoted.

Sickness benefits

While maternity is not a sudden illness, it often involves medical needs that may overlap with eligibility criteria for sickness benefits. For example, where maternity benefits do not cover prenatal complications that require time off or bed rest (including severe morning sickness or high blood pressure), women may need to exhaust their entitlements to sickness benefits to cover these periods. Similarly, women may continue to face health complications after the prescribed duration of maternity benefits, including postpartum depression or surgical recovery, during which they may therefore need to rely on sickness benefits. In some circumstances, women may need time off work to access rehabilitation care. Where provisions are not made to allow for extensions of the duration of maternity benefits due to such complications, reliance on other entitlements, including sickness benefits, may therefore be required to cover these periods. In turn, these sickness benefits may not provide the same level of income support as maternity benefits, effectively penalizing women who are experiencing such complications. Globally, both maternity and sickness benefits tend to be underdeveloped in social protection systems, and labour legislation largely relies on employer liability, which is a less robust mechanism in terms of effective coverage, risk pooling and financing.

Ensuring that maternity benefits and sickness benefits combined comprehensively cover the full range of possible pregnancy-related illnesses and complications (both before and after delivery) is therefore essential to ensuring adequate protection.

Long-term benefits: pensions in case of permanent disability, old age and survivorship

Ensuring coherence between maternity benefits and long-term benefits, such as old-age and disability pensions, is essential to addressing potential disadvantages that women may face as a result of their reproductive roles. Periods of maternity and related time spent on caring responsibilities for children may lead to gaps in contributory histories for long-term benefits, which may ultimately affect entitlement to benefits, or result in lower entitlements to old-age pensions or disability benefits, perpetuating gender inequalities in access to adequate protection.

One approach adopted to mitigate this risk is to treat periods of maternity or care leave as periods of active contributions, whether by providing time-based credits to contributory histories or financial credits to long-term benefits accounts (ILO 2024c, 2024d). For example, the Social Protection Fund in Oman covers the cost of pension contributions for women during maternity leave, thus avoiding the potential negative impact of paid leave on women's future pension entitlements (ILO 2024a).

It is also important to acknowledge that in many countries, particularly in Asia where the population is ageing rapidly, women are at the forefront of providing care for elders and household members experiencing various degrees of disability. Income insecurity among these household members also creates hardship for their carers, which is exacerbated when they are pregnant, giving birth or caring for a newborn. Securing pensions of adequate levels and bridging the gender gap in pension coverage and adequacy is therefore crucial (ILO 2024a).

Lastly, it is important to acknowledge the additional challenges encountered by women living with disabilities in

accessing adapted healthcare services without hardship, including when it comes to sexual and RMNCH services, and securing income security. Ensuring that women with disabilities – whether these are linked to a work-related injury or disease or not – can access disability benefits, cover the extra costs of disability and access disability-sensitive social protection, including maternity benefits and social health protection, is therefore central (ILO 2024a; Razavi et al. 2024; ILO 2025).

Complementarity between maternity benefits and other policy areas

Beyond the social protection system, international social security standards and recommendations further emphasize the principle of coherence within social, economic, employment and health policies to underpin national social protection floors. This is especially relevant during pregnancy and childbirth, when the objectives of social protection in preventing impoverishment and ill health are a necessary component of both broader health policies and decent work promotion policies. This makes intersectoral coordination and collaboration in this context essential.

Health policies

Social protection benefits provided during maternity (including income security and access to free maternity healthcare services) have an intrinsic objective to protect and promote the health and well-being of mothers and newborns. As such, they are an integral part of any national policy on maternal and child health. While such social protection benefits aim at overcoming the financial barriers to accessing maternal care and their opportunity costs in terms of lost working time/income, their success in this respect is closely tied to the health system's capacity to deliver these services in a way that meets the AAAQ criteria. In the absence of a coherent approach, coverage under such social protection benefits may not translate into effective access to services and improved health outcomes. Despite this, as outlined below, there has been very slow progress over the past few decades in improving indicators related to service coverage of RMNCH (WHO and World Bank 2023).

Thus, social protection and health systems must work in close coordination to align priorities on maternity protection and ensure that coverage extension is matched by efforts to strengthen health systems and health policy frameworks on maternal health. Through the design of benefit packages and more strategic purchasing, social health protection mechanisms have the potential to influence the quality and availability of services, including maternity services. In this context, priorities could include, for example, strengthening the role of primary health facilities to deliver a comprehensive range of services, including promoting greater continuity of care and, and strengthening their capacity as referral and information gateways on social protection programmes for maternity (ILO 2026b, 2021a).

At the same time, socio-economic factors are key determinants of the health outcomes of pregnant women and newborns, driving inequities in health outcomes between different population groups and increasing demands on the health system. Social protection systems can contribute to addressing these social determinants of health, if designed holistically, by securing comprehensive and adequate protection across the lifecycle and ensuring coordination with complementary policy areas.

Nutrition policies

The effectiveness of social protection during maternity is also significantly tied to the effectiveness of nutrition and food security policies. The first 1,000 days of a child's life (from conception to a child's second birthday) is a crucially important period during which maternal and infant nutrition not only significantly influence health outcomes during pregnancy and delivery, but also influence the longer-term health and developmental outcomes of the child (Alderman 2015; FAO et al. 2024).

Ensuring coherence and coordination between social protection during maternity and nutrition and food security policies is therefore crucial to promote long-term well-being and prosperity. There are several crucial considerations in this context:

- In relation to access to healthcare services without financial hardship, the maternal benefit package needs to take into consideration interventions that are complementary to medical care, including the provision of relevant micronutrient supplements during pregnancy, as well as effective counselling on infant and child nutrition and breastfeeding practices (Stevens et al. 2015; Maramag et al. 2023; Alhaji et al. 2017). Recommendations in relation to breastfeeding practices are also closely tied to women's entitlement to breastfeeding breaks upon return to work, highlighting the core interrelation with labour rights (Hernández-Cordero et al. 2022).
- In turn, the importance of nutrition to the health and developmental outcomes of mothers and children reinforces the importance of coordination between healthcare and income security benefits, as food often constitutes a large share of household expenditure (ILO and FAO 2021). Enhancing the adequacy of social protection cash benefits helps to ensure that the nutritional needs of mothers and children can be effectively met, especially during the crucial first 1,000 days (Aitken et al. 2015; Jou et al. 2018).

Employment policies

Globally and in Asia and the Pacific, labour markets are marked by persistent gender gaps and inequalities which constrain women's access to paid employment and social insurance schemes. The participation of women in employment still lags more than 20 percentage points behind men globally, they experience a significant gender pay gap, are concentrated in occupations and sectors in which earnings are lower, and are at higher risk of being in the informal economy, in self-employment, and in part-time work. All of these factors are enhanced by childbirth, and labour economists have noted a "motherhood penalty" affecting women's ability to access employment on par with men. Giving birth and having young children in the household are correlated with lower labour market engagement of women. These structural disadvantages limit women's opportunity to affiliate and contribute to social insurance (Razavi et al. 2024). While social assistance programmes exist, they generally provide lower levels of benefits, particularly in the case of cash benefits. Therefore, women's difficulties in accessing decent employment impacts their access to social insurance which, in turn, impacts the adequacy of the social protection benefits they can receive in case of maternity (ILO 2016).

In Asia and the Pacific, women tend to be employed in sectors that are associated with decent work deficits, in which the range of labour protections outlined in Convention No. 183 are not guaranteed (ILO and ADB 2023a). The Transition from the Informal to the Formal Economy Recommendation, 2015 (No. 204) provides guidance on the adoption of holistic approaches to facilitate the transition of workers and economic units from the informal to the formal economy, while respecting workers' fundamental rights and ensuring opportunities for income security, livelihoods and entrepreneurship.

As mentioned in the previous section, it is important to recognize that the mechanisms through which maternity cash benefits are financed may themselves affect women's rights in employment. Where there is no social protection and employers are liable to pay salaries during maternity leave, they may discriminate against women of childbearing age in recruitment processes or unfairly dismiss women who become pregnant to avoid bearing the direct cost of the benefits. As such, ILO standards require that cash benefits during maternity be provided through social protection schemes based on solidarity and risk pooling. It is equally important to ensure coherence across labour and social security legislation in relation to the entitlements they afford during maternity.

Gender equality

It is essential to recognize the intersecting vulnerabilities and discrimination faced by women and girls in relation to their access to healthcare services and social protection to ensure that the design of social protection programmes for maternity effectively meet their objectives. Indeed, gender inequality is recognised as a social determinant of health. For example, social norms constrain the ability of women and girls to make decisions about healthcare and contraception, with negative consequences on health-seeking behaviours (UNFPA 2021). Furthermore, women and girls' effective access to services may be constrained by a range of compounding factors,

including lack of awareness of their rights and entitlements, limited financial resources and the de-prioritization of their healthcare needs within household budgets (WHO 2009). Supply-side challenges, as highlighted above, may also constrain the ability of women to effectively access the services they need, and these services may not be gender sensitive. These factors are compounded by women and girls' more limited access to cash benefits under social protection schemes compared with their male counterparts, heightening vulnerabilities that affect their health and well-being (ILO 2024a).

The design and implementation of social protection during maternity needs to recognize and take account of these intersecting vulnerabilities to avoid entrenching disparities and to ensure effective access to rights and entitlements. This requires considerations about how coverage can be extended to all women and girls, including the most marginalized, by taking account of disparities across geographical, educational and socio-economic dimensions, while also ensuring the adequacy and responsiveness of entitlements, and their effective coordination (ILO 2026b).

It is equally essential to adopt a gender equality lens in the design and implementation of maternity benefits within the broader scope of parental leave and care policies (ILO 2024a). The design of paid leave entitlements – both for women and men – before and after childbirth can directly contribute to gender equality in the labour market. As highlighted in the Resolution concerning decent work and the care economy adopted by the International Labour Conference in 2024 as well as the 2021 Resolution concerning the second recurrent discussion on social protection (social security), which recognizes the importance of designing gender-responsive social protection policies, when carefully designed to take account of gender roles, improving parental leave entitlements can enable parents to better share care responsibilities within the household, which can positively contribute to women's economic inclusion and closing gender gaps in the world of work (ILO 2024e).

Beyond considerations within the social protection system, it is also important to ensure coordination between social protection and wider gender equality policies that aim to address the intersecting vulnerabilities faced by women and girls, and to consider how social protection itself can contribute more actively to gender equality. This is especially the case in relation to coordination and coherence across paid leave entitlements and childcare policies.

Childcare policies

As previously noted, due to the disproportionate share of unpaid care work that they take up, women are more likely to have interrupted or shorter careers, to engage in part-time work and to be compelled to undertake more precarious work so they can combine paid with unpaid work, which in turn affects their access to social insurance. This in mind, childcare plays a crucial role in the continuum of care policies, essential not only for early childhood development, but also for the economic inclusion of women (Addati, Cattaneo and Pozzan 2022). Its importance for women and men workers is recognized in the Workers with Family Responsibilities Convention, 1981 (No. 156). Across the world, including in Asia and the Pacific, gaps in childcare policies (whether in terms of provision, accessibility or affordability) result in a situation where the labour of caring for children falls disproportionately on women, with significant implications for women's meaningful participation in social, economic and political domains of life (ILO and ADB 2023b).

It is particularly important in this context to promote coherence and alignment between paid parental leave entitlements and statutory childcare provision. This is especially key to closing the “childcare policy gap” – This is especially key to closing the “childcare policy gap” – the period between the end of statutory childcare-related leave and the starting age for free, universal early childhood care and education or primary education (Addati, Cattaneo and Pozzan 2022). The absence of integrated care provision that leads to such gaps has significant implications for gender inequalities within the household, at work and within wider society, with detrimental short- and long-term impacts on well-being and prosperity.

Alignment here requires consideration of how to harmonize paid leave entitlements and childcare policies, but also strengthened investments in care policy packages, wherein gaps continue to persist throughout the world, including in the Asia-Pacific region (ILO and ADB 2023b).

► 3 Social protection during maternity in ASEAN Member States

Key messages

- There are gaps in legal coverage of both cash benefits and social health protection, which depend on labour force participation, status in employment, informal nature of employment, citizenship and residential status, and geographical location, highlighting stark **inequities**. This is true of both cash and healthcare benefits, but it is more pronounced when it comes to cash benefits.
- Some countries continue to rely on **employer liability** mechanisms for maternity cash benefits, whether in part or in full. These modalities may limit access to benefits or the adequacy of benefits where compliance is low, while also generating incentives for discrimination against women of reproductive age in the labour market.
- The **adequacy** of provided benefits is also a concern:
 - Significant **differences in entitlements** between distinct categories of women prevail, especially between formal and public sector workers, compared with self-employed workers, those in informal employment, and migrant workers. While some efforts are being made in certain contexts (including in Thailand) to promote greater coherence, promoting social justice and health equity calls for greater harmonization and a reduction of inequities in entitlements.
 - In a few contexts, maternity cash benefits are paid as **lump sums** (including for specific categories of the population), which do not afford adequate protection during maternity.
 - Data on the **benefit packages** of several social health protection mechanisms across ASEAN Member States are defined implicitly or not readily available. This makes it difficult to ascertain whether all the essential health services required during maternity are included and effectively provided, accessed and used. Many countries continue to apply **co-payments** to access maternal, neonatal and child health under health protection mechanisms.
- While some countries promote a level of **coherence** between maternity cash benefits and access to necessary healthcare services during maternity, including by providing for paid time off to attend antenatal care, this is not universally the case; further reflection on alignment and coherence is required in several contexts. The lack of **sustainable and sufficient financing** for health and social protection in general, and for benefits and services geared at women and children in particular, remains a significant determinant of gaps in coverage and adequacy, which needs to be urgently addressed.
- **Disaggregated data** on the share of the population protected against the costs of accessing healthcare is urgently needed to inform a better understanding of differences in access to RMNCH services by geography, age and migration status, among other characteristics. It is also needed to track public expenditure on social protection during maternity.

Legal coverage

The types of financing arrangements to guarantee income security and access to healthcare without hardship during maternity influence the coverage of social protection benefits during maternity. The following section outlines the legal coverage of different population groups for the region's various benefits and schemes, as defined by national legislation and policies

Maternity cash benefits

Certain countries in the region continue to rely in whole or in part on employer liability to secure an income during maternity leave. For example, Indonesia and Malaysia rely exclusively on employer liability and do not have social protection schemes. Such provisions are de facto limited to female employees, can encounter significant enforcement issues, create incentives to discriminate against women of reproductive age in the labour market, and can put business continuity at risk in small and medium-sized enterprises and in sectors where the workforce is prominently female (Addati et al. 2022; ILO 2023a, 2024f, 2026b).

In Brunei Darussalam, Cambodia, the Lao People's Democratic Republic (Lao PDR), Singapore and Thailand, maternity related cash benefits are combined with employer liability. In Brunei Darussalam and Singapore, employers are liable to continue paying the salary for the first part of the maternity leave, while tax-financed programmes complement this by providing cash benefits for the remainder of the maternity leave period. This applies to the first two births in the case of Singapore, whereas the third and subsequent births are covered entirely by the non-contributory social protection schemes. In both cases the employer advances the salary payment and subsequently claims reimbursement from the tax-financed scheme. Self-employed women are entitled to the tax-financed maternity benefits in Singapore for the entire duration of their maternity leave.

A similar model operates in Thailand, where the employer is liable to cover the first 60 days of maternity leave, but it is the social insurance scheme (which is mandatory for employees and voluntary for self-employed workers) that covers the remaining 90 days of maternity leave with cash benefits. In the case of self-employed workers, coverage by the social insurance scheme is voluntary and covered members can choose from different packages of benefits.

Conversely, in Cambodia and Lao PDR, employer liability and social insurance mechanisms complement each other in terms of the share of income that they respectively replace. In Cambodia, employers are liable to pay 50 per cent of previous earnings during maternity leave, while the social insurance scheme provides 70 per cent of previous earnings for covered women (which is mandatory for employees and voluntary for the self-employed). Both payments are provided for the same period of maternity leave. In Lao PDR, the social insurance scheme covers 80 per cent of reference earnings during this period, while employers are liable to cover the remaining 20 per cent during the 105 days of maternity leave.

In Myanmar, the Philippines, Timor-Leste and Viet Nam, maternity benefits are exclusively guaranteed by social insurance mechanisms. These are typically mandatory for employees, but voluntary for self-employed and other categories of workers, which, in some cases, entitles covered members to a different range of entitlements (see next section on adequacy of benefits).

The above-mentioned mechanisms aim to replace income during maternity leave and thus prevent poverty and vulnerability for pregnant women in employment. As mentioned in chapter 2, there are also non-contributory cash transfer programmes, such as in Cambodia, Indonesia, Lao PDR, Malaysia, Myanmar, the Philippines, and Timor-Leste, that aim to support income and alleviate poverty either for all women, or with a focus on vulnerable women. While in Indonesia, the Philippines, and Timor-Leste, the cash transfer programmes have a legal or statutory basis, contributing towards their sustainability, this is not the case in Cambodia, Myanmar and Lao PDR, where schemes remain relatively disparate and are largely financed through donor funding. In some cases, such non-contributory social protection programmes are targeted specifically at pregnant women and mothers with children under 2 years of age and designed to meet their specific needs, as is the case with the Helping Hands Programme in Lao PDR, the Mamakerja programme in Malaysia, and the Maternal and Child Cash Transfer programme in Myanmar. In other cases, such as in Cambodia, Indonesia, the Philippines and Timor-Leste, programmes are not exclusively targeted at pregnant and lactating women, but rather, the presence of a pregnant woman or newborn within a household is an eligibility criterion for programmes that aim to reach a wider target population. In all cases except for Myanmar, the programmes are means-tested. In most cases, the cash transfer programmes include behavioural conditions, whereby access to benefits is

conditional on uptake of prenatal and postnatal care or delivery attended by a skilled professional. While these types of conditions aim to strengthen access to crucial maternal, neonatal and child health care services, they risk reinforcing the traditional division of paid and unpaid care work between women and men (ILO 2016). They also require that the services needed to meet the requirements are effectively available and meet the AAAQ criteria (Razavi et al. 2024).

► **Table 1: Legal entitlements to paid maternity leave and social protection maternity cash benefits in ASEAN member states, by type of programme**

	Employer liability	Social insurance	Tax-financed maternity cash benefits	Tax or donor financed cash transfer programmes whose coverage includes pregnant and lactating women
Brunei Darussalam	X		X	
Cambodia	X	X		X
Indonesia	X			X
Lao PDR	X	X		X
Malaysia	X			X
Myanmar		X		X
Philippines		X		X
Singapore	X		X	
Thailand	X	X		
Timor Leste		X		X
Viet Nam		X		

Source: country profiles in annexes of this report.

In terms of legal coverage, the share of women of working age (over 15 years old) covered by mandatory maternity social insurance in ten ASEAN countries remains at 19.4 per cent, which is lower than the global average and the average in the Asia-Pacific region (26.4 per cent and 26.7 per cent, respectively). There are significant differences across countries. While high- and middle-income countries tend to cover almost half of working age women, low-income countries lag behind, with less than a quarter covered (figure 5).

Countries relying entirely or in part on employer liability mechanisms legally or de facto exclude self-employed workers from coverage. For example, self-employed workers are not eligible for maternity leave or maternity cash benefits under the Employment Act of 2009 in Brunei Darussalam, and in Indonesia and Malaysia, they are also de facto excluded from coverage.

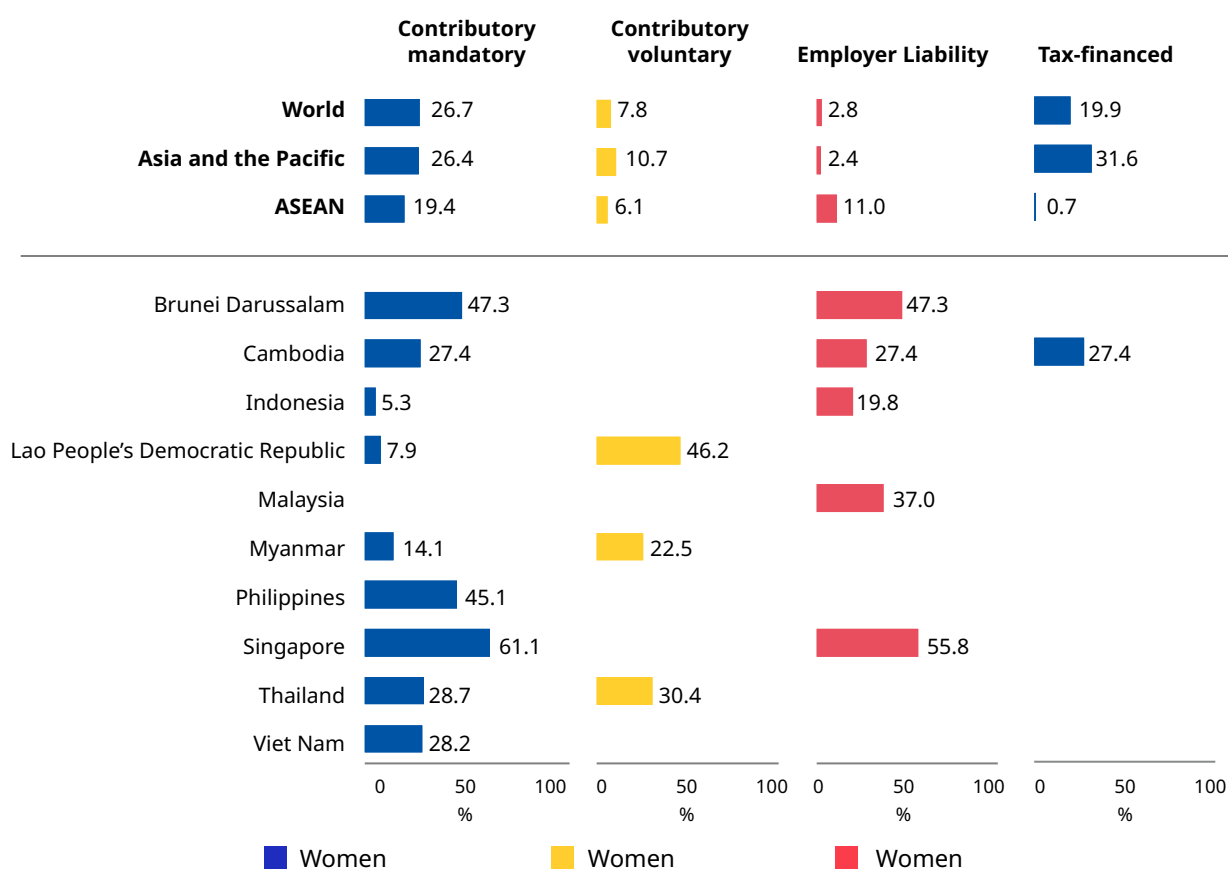
In Cambodia and Thailand, the self-employed are only eligible for maternity entitlements provided by the social insurance scheme if they are enrolled, which is voluntary for self-employed workers in both countries. Singapore is the exception, as noted above, where maternity benefits for self-employed women are fully covered by the tax-financed mechanism. Self-employment represents the majority of female employment in Cambodia and Indonesia, and close to half of female employment in Thailand, while representing a much smaller share in Brunei Darussalam and Singapore. Data for Malaysia are not available.

Coverage of existing schemes may also be limited due to legal exclusions or differential entitlements for specific categories of workers. For example, domestic workers are legally excluded from the scope of application of the laws governing maternity cash benefits in Indonesia, Malaysia, Singapore and Thailand, while in Timor-Leste, they are only covered by social insurance on a voluntary basis. Similarly, contributing family workers are only covered on a voluntary basis under the social insurance scheme in Myanmar.

In some contexts, migrant workers may be excluded from the scope of coverage or entitled to different, and typically less generous, benefits (see next section), despite representing a significant share of the labour force in several contexts in ASEAN (figure 5). For example, in Brunei Darussalam, citizens and permanent residents are covered by a combination of employer liability and tax-financed mechanisms, while foreign workers are exclusively covered by the employer liability mechanism.

In Singapore, where female migrant workers represented 63.8 per cent of the total female labour force in 2022, migrant workers are categorized into different groups, some of which are entitled to benefits that are less generous than those of citizens; meanwhile, others (typically unskilled) are not allowed to keep their contract if they get pregnant and are therefore deported. Both in Myanmar and Timor-Leste, migrant workers are covered only on a voluntary basis under their social insurance schemes. In the case of all the cash transfer programmes mentioned above, coverage is limited to citizens.

► **Figure 5: Share of women in working age over 15 years old covered by maternity cash benefits, by country, income level and region in 2023 or latest available year.**



Note: Global and regional aggregates are weighted by the population of women of working age. As data for Timor-Leste are unavailable, the country was excluded from the weighted average calculations.

Source: ILO estimates, World Social Protection Database, based on the Social Security Inquiry; ISSA Social Security Programs Throughout the World; ILOSTAT; national sources.

Healthcare benefits during maternity

Access to maternal, neonatal and child healthcare services without financial hardship is typically (although not always) integrated within mechanisms that provide healthcare benefits for a wider range of healthcare needs, including outside of the maternity period, with a few exceptions. It is therefore important to have an overview of the type of social health protection schemes that countries have adopted (ILO 2021a):

- Brunei Darussalam, Malaysia and Timor-Leste operate **national health services**, where services are financed and provided directly by the Ministry of Health for free or with minimal user fees in public facilities (although private facilities operate alongside this, where user fees are applied). In Brunei Darussalam, services are provided free of charge at primary, secondary and tertiary levels of care, while in Malaysia, services are provided almost free of charge at the primary level and are substantially subsidized at secondary and tertiary levels. In Timor-Leste, the national health service covers care at the primary level, with the objective of developing a comprehensive benefit for secondary and tertiary levels of care by 2030.
- In Indonesia, the Philippines and Viet Nam, maternal, neonatal and child healthcare services are integrated within **national health insurance schemes**. These include Indonesia's Jaminan Kesehatan Nasional (JKN) scheme, the Philippines' National Health Insurance Programme (Philhealth), and the Viet Nam Social Security (VSS) scheme, all of which legally cover the entire resident population on a mandatory basis. These schemes combine a range of financing arrangements, including contributions from workers and employers, as well as tax-financing to fully or partially subsidize the contributions of informal workers and vulnerable groups.
- In Cambodia, Lao PDR, Myanmar, Singapore and Thailand, maternal, neonatal and child healthcare services are integrated within the **range of different schemes** (whether contributory or not) that operate within each country, providing coverage to different categories of the population. In Thailand, formal workers in the private sector are covered by contributory social health insurance schemes, while the rest of the population is covered by tax-financed schemes. In Lao PDR, formal workers in both public and private sectors are covered by contributory social health insurance, while the rest of the population in rural areas is covered through the National Health Insurance scheme on a non-contributory basis. Informal workers in Lao PDR's Capital of Vientiane currently experience a coverage gap for social health protection, and therefore a vertical non-contributory programme covering maternal and child healthcare services operates in the city. Similarly, two schemes also operate in Cambodia – one covering formal workers with the aim to expand coverage to self-employed workers on a voluntary basis, run by the National Social Security Fund (NSSF), and a non-contributory scheme, run by the Health Equity Fund (HEF), which covers only the most vulnerable groups. In Myanmar, a social health insurance scheme for formal workers guarantees access to healthcare services without financial hardship, while for uncovered groups, public facilities provide services for a small user fee.

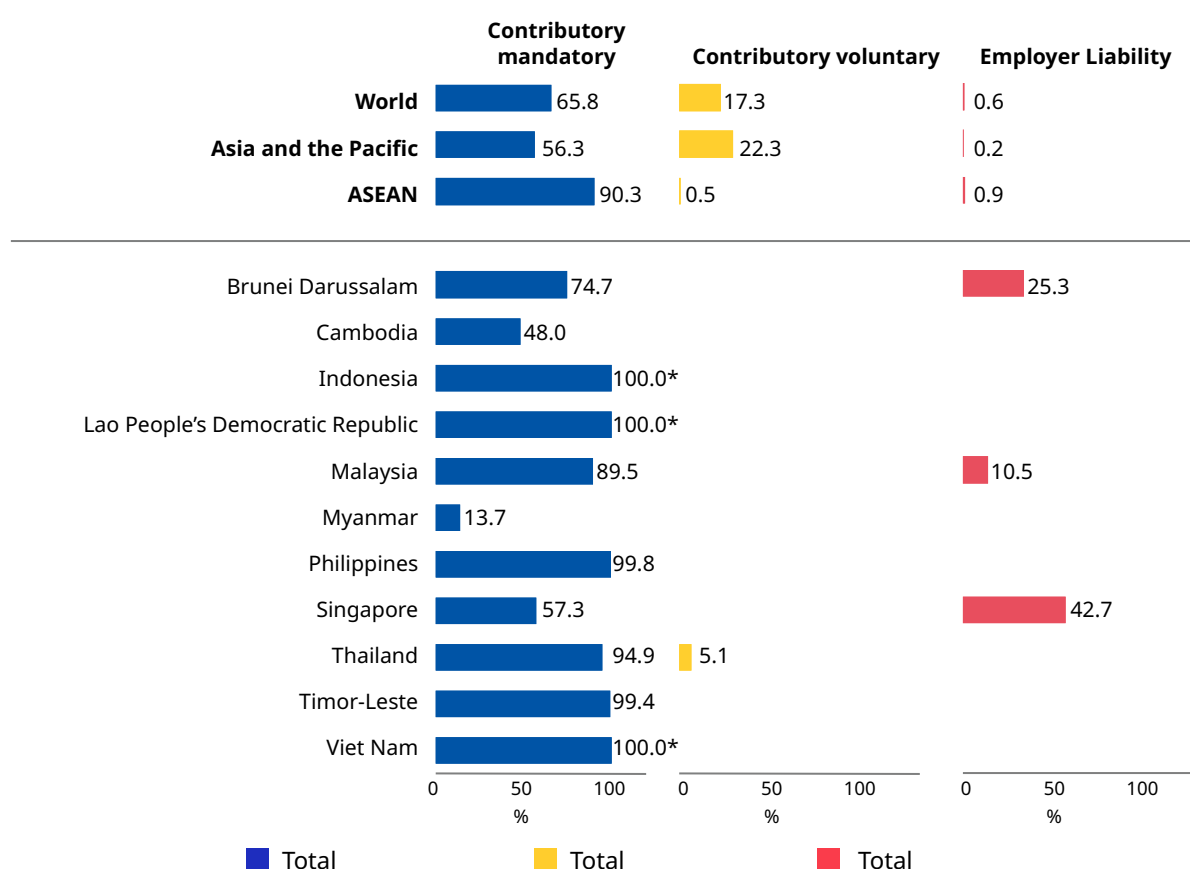
In the majority of countries in ASEAN, the entire resident population is legally entitled to access healthcare services without hardship, above both global and regional averages (figure 6). This situation reflects the significant commitment of ASEAN countries to extend social health protection to all. Thailand was a frontrunner in this regard, with the launch of its Universal Coverage Scheme (UCS) that consolidated prior voluntary schemes for informal workers and social assistance schemes for vulnerable groups and rapidly secured near-universal coverage. In Indonesia, the Philippines and Viet Nam, reforms to the legal framework have been accompanied by broad reforms to consolidate national health insurance under a single payer umbrella (ILO 2021a, 2020b).

Yet, some significant gaps remain. In many countries, migrants and refugees are excluded from social health protection entitlements provided by the law, the coverage of which is explicitly limited to citizens or permanent residents, including in Brunei Darussalam, Indonesia, Lao PDR, the Philippines, Singapore, and Viet Nam. In Brunei Darussalam, Malaysia, Singapore, they are covered through private mechanisms that are the liability of their employer. In these contexts, migrant workers on temporary work permits can access the national health

service with higher user fees. In Malaysia and Singapore, there is legislation providing that employers purchase private health insurance for them. In Thailand, the rights of migrants to social health protection coverage depend on the scheme and the status of the migrants themselves: migrants are excluded from the UCS, but documented migrants in formal employment can access the scheme administered by the SSO, and undocumented and documented migrants who do not fall under categories covered by the compulsory social security scheme are covered under the Migrant Health Insurance (MHIS) scheme, which is voluntary for irregular migrants. However, recent qualitative research highlights that women migrant workers have reported being refused renewal in the MHIS on the basis of their pregnancy (Sitkulanan et al. 2024).

In Cambodia, and to a lesser extent Lao PDR, there are legal gaps affecting workers in the informal economy. Since women of reproductive age are at greater risk of being employed informally and are represented strongly among migrant workers in the region, it is crucial to close these legal gaps, as a matter of urgency. In the face of these gaps, they are de facto excluded from the maternity care provisions included in general social health protection schemes.

► **Figure 6: Share of the population legally entitled to access healthcare services without hardship by country, income level and region in 2023 or latest available year.**



Note: Global and regional aggregates are weighted by population.

*Indonesia: refugees and asylum seekers are excluded, as well as foreigners who have not worked in the country for at least six months; Lao People's Democratic Republic: non-formal workers in the Vientiane Capital are not included; Viet Nam: refugees, asylum seekers, and certain categories of migrants are not covered.

Sources: ILO estimates, World Social Protection Database, based on the Social Security Inquiry; ISSA Social Security Programs Throughout the World; ILOSTAT; national sources.

Paternity and parental benefits

Eight of the 11 ASEAN Member States provide for paternity leave. In Cambodia and Lao PDR, while no dedicated paternity leave is provided for, male workers can take from their “special leave” entitlements for the birth of a child. Paid paternity leave remains an employer’s liability in most countries in which these provisions exist, while paternity cash benefit entitlements exist in four countries. These are financed through social insurance in three countries and tax-financed in Singapore (see table 2). Only Singapore provides for paid parental leave, while such provisions do not exist in the remaining ASEAN Member States.

► **Table 2: Financing of paternity and parental cash benefits**

	Source of funding of paternity cash benefits	Source of funding of parental cash benefits
Brunei Darussalam	N/A	N/A
Cambodia	Employer-liability*	N/A
Indonesia	Employer-liability	N/A
Lao PDR	Employer-liability*	N/A
Malaysia	Employer-liability	N/A
Myanmar	Social insurance	N/A
Philippines	Employer-liability	N/A
Singapore	Tax-financed	Tax-financed
Thailand	Employer-liability	N/A
Timor-Leste	Social insurance	N/A
Viet Nam	Social insurance	N/A

*: No dedicated paternity leave. “Special” or “personal” leave entitlements cover paid time off for a range of contingencies, including the birth of a child.

Source: country profiles in annexes of this report.

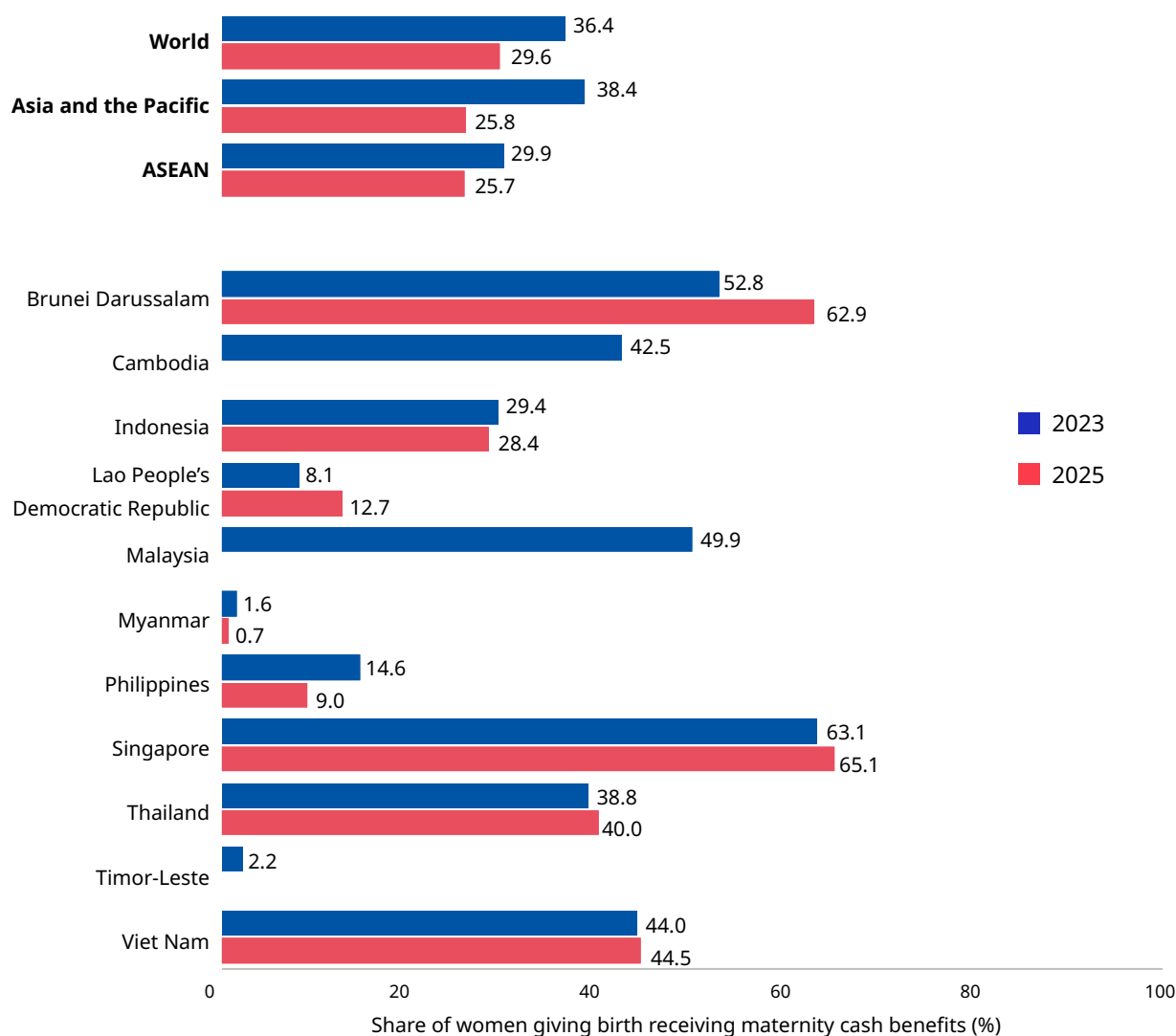
Effective coverage

In this section, the effective coverage of social protection benefits for income security and access to healthcare without hardship during maternity are presented.

Maternity cash benefits

Across ASEAN, effective coverage of maternity cash benefits is low, and below global and regional averages. According to data from 2023, only 29.9 per cent of women giving birth in ASEAN countries received maternity cash benefits, compared with 38.4 per cent in Asia and the Pacific, and 36.4 per cent of the global population. This data hides significant differences in coverage across ASEAN Member States, with coverage reaching 63.1 per cent in Singapore, compared to only 1.6 per cent in Myanmar (figure 7). While there has been progress in some countries, overall it has remained stagnant, and slightly declined between 2015 and 2023.

In several contexts, self-employed workers are only covered on a voluntary basis by social insurance schemes guaranteeing maternity cash benefits, including in Cambodia, Lao PDR, Myanmar, Thailand and Viet Nam. International experience typically shows low uptake of voluntary schemes due to competing demands on household budgets, as is the case in Cambodia and Lao PDR, for example. However, the mandatory and voluntary schemes in Thailand achieve almost the same level of coverage.

► **Figure 7: Share of women giving birth receiving maternity cash benefits, by regional and selected countries, 2015 and 2023 (percentage)**

Note: Global and regional aggregates are weighted by number of women.

Source: ILO modelled estimates, 2024, World Social Protection Database, based on the Social Security Inquiry; ISSA Social Security Programs Throughout the World; ILOSTAT; national sources

A range of structural constraints and discriminatory social norms also exist that drive gender inequalities, which may affect women's access to maternity cash benefits, including in relation to their status in employment, or their capacity to contribute, for example. In several countries in ASEAN, the **labour force participation** rate of women is relatively low by regional and global standards, as is the case in Lao PDR, Myanmar and Timor-Leste, for example (Figure 8). While there is a wide range of explanatory factors behind the low labour force participation rate of women in several contexts, societal expectations, gender norms and gender stereotypes around caregiving and work remain among the main drivers. At a global level, care responsibilities are the main barriers preventing women from participating in the labour force, while men usually cite other personal reasons, such as education or illness (ILO 2024f).

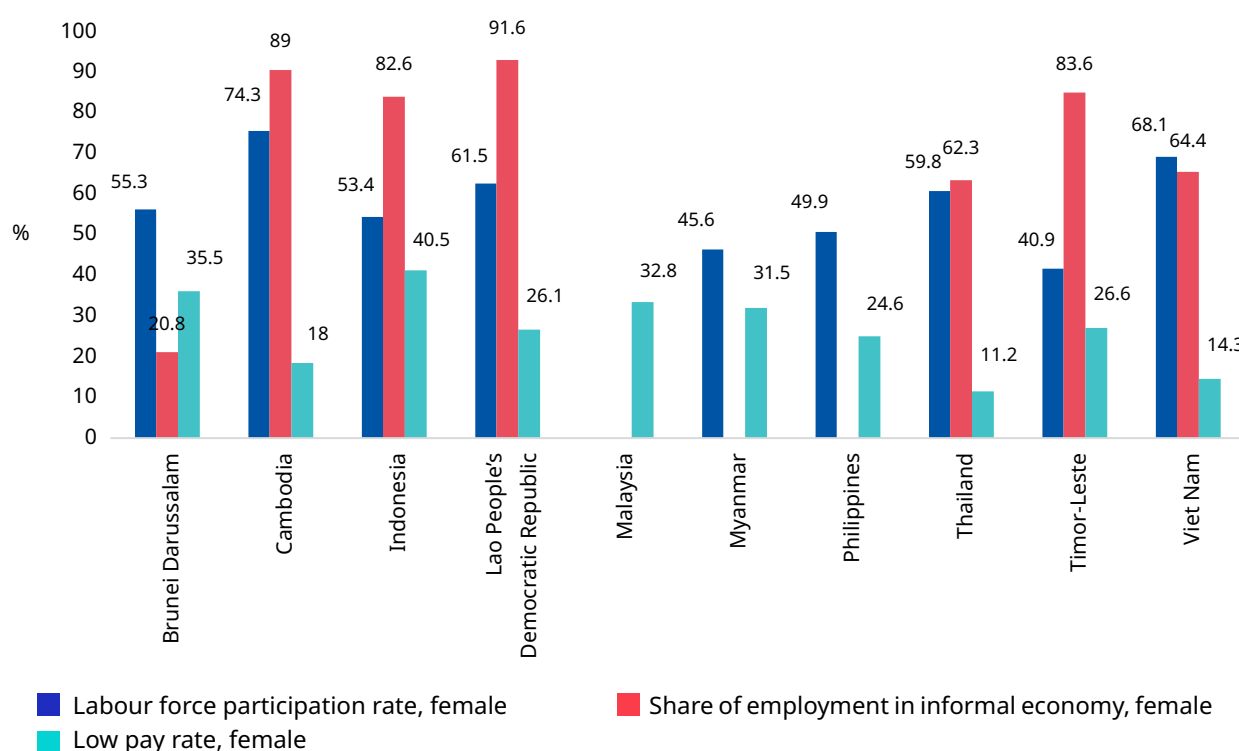
Similarly, effective coverage (or effective application of the law) may be limited by the high rate of **informal employment** within female employment in ASEAN. As illustrated by Figure 8, while informal employment as a share of total female employment varies substantially across ASEAN countries, ranging from 20.2 per cent in

Malaysia to 89 per cent in Cambodia, it is clear that informal employment dominates female employment in the majority of countries in ASEAN.

The high rate of informal employment among women in employment is driven by several factors, including that women are more likely to have an employment status prone to vulnerability and low pay than their male counterparts. For example, in Lao PDR, 47 per cent of the employed population are contributing family workers, and women make up 55 per cent of this group (Merttens et al. 2024). These forms of employment are characterized by significant decent work deficits, such as gaps in protections (including those related to maternity) afforded by the provisions of labour or employment laws, or by employer liability mechanisms. Informal employment also constrains women's access to social protection, including schemes guaranteeing maternity cash benefits.

In turn, women may have low **contributory capacity**. In seven out of the nine countries for which data were available, the low pay rate (the share of employees whose hourly earnings from all jobs are less than two thirds of the median hourly earnings) is higher among women than men, reaching over 40 per cent among women in Indonesia and over 30 per cent in Malaysia and Myanmar. This reality may negatively affect women's capacity to afford contributions under contributory mechanisms, including social insurance schemes. It may also have implications for the adequacy of benefits afforded (see next section).

► **Figure 8: Female labour force participation rate, informal employment rate and low pay rate, by selected countries, latest year available**



Note: Data refer to the latest year available, which varies by country and indicator. Female labour force participation rate refers to the share of working-age women (aged 15 and above) who are employed or actively seeking work. Share of informal employment refers to the proportion of employed women working in the informal economy. Low pay rate refers to the share of female wage employees earning below two-thirds of the median wage. Data for Malaysia and Singapore are unavailable for labour force participation and informal employment. Data for Singapore are unavailable across all three indicators. Data for Brunei Darussalam (low pay, 2014) and Malaysia (low pay, 2015) refer to older survey rounds and should be interpreted with caution.

Source: Based on data from the ILO, 2026, ILOSTAT database.

The basic needs of pregnant women outside of the labour market, recognizing the costs associated with giving birth and welcoming a new child, are equally important to consider. While tax-financed schemes exist that could aim to provide some protection for such women, they tend to be poverty targeted and narrow in scope, achieving limited geographical and effective coverage. For example, such schemes in Lao PDR and Myanmar are implemented only in specific regions of the country. In turn, in Malaysia, cash transfer programmes operate at the subnational rather than at the national level and are not implemented in all States. In Cambodia, Indonesia and the Philippines, however, these schemes are implemented at the national level, covering the entire territories of these countries. These and other factors contribute to wide variations in terms of the effective coverage of these schemes. The scheme in Myanmar for example, reached only 1 per cent of the population in 2020 (Central Statistical Organization of the Republic of the Union of Myanmar 2020), while the programme in Indonesia aims to cover the poorest 20 per cent of households, although it is not known what share of this coverage includes households with pregnant and lactating women.

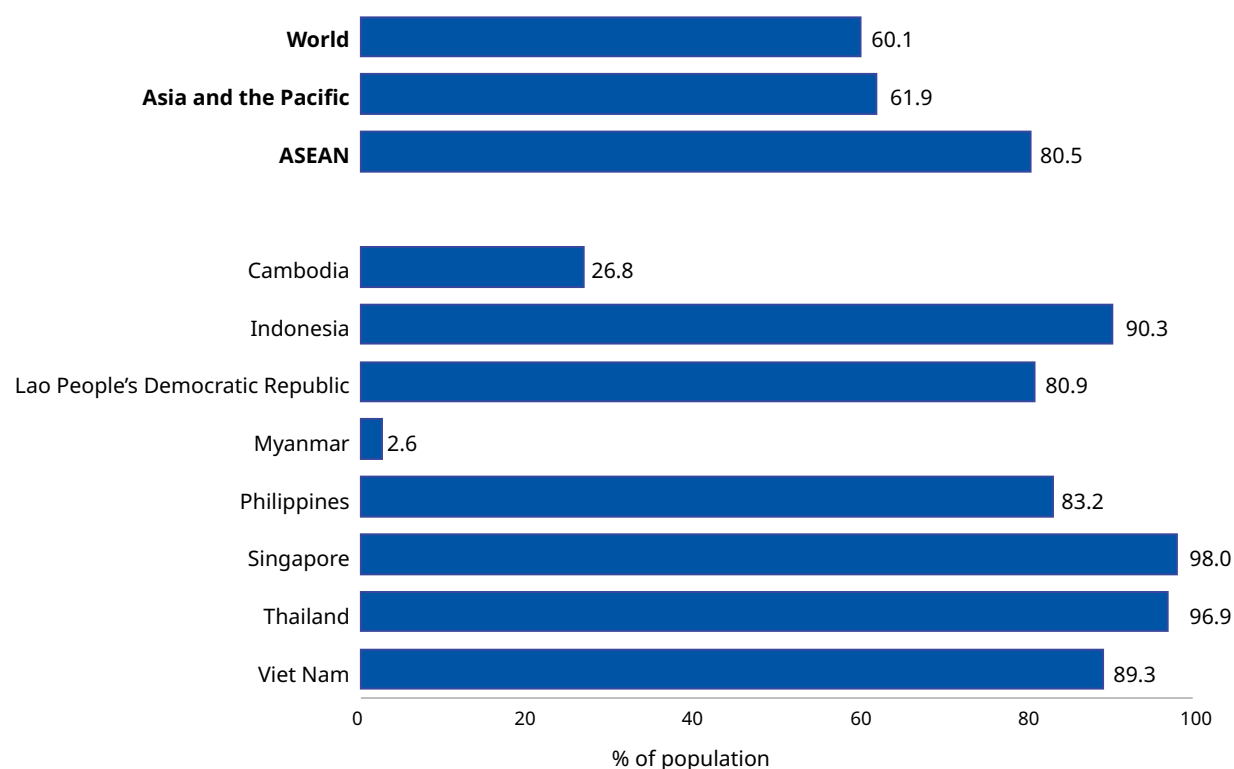
These barriers to access, many of which derive from structural inequities between women and men, highlight the importance of aligning social protection policies with wider efforts to address gender inequalities, in the labour market and beyond.

Healthcare benefits during maternity

Data on the share of women giving birth who are effectively protected by a scheme that guarantees their right to access healthcare services for free, or with limited co-payments, are not currently available at the global level. Monitoring progress on population coverage requires more investment in the collection of data disaggregated by sex and age, but also by place of residence, disability, migratory status, income level and socio-economic conditions.

While this holds true, effective coverage of social health protection as a whole provides some level of understanding of the gaps in effective coverage of maternity care without hardship. The ILO estimates that 80.5 per cent of the population in ASEAN countries is effectively protected by a scheme that guarantees access to healthcare services without financial hardship. This coverage is higher than both regional and global averages, at 61.9 and 60.1 per cent respectively. Yet, once again, this data hides stark differences between countries within ASEAN, ranging from near universality to less than five per cent coverage (figure 9).

► **Figure 9: Share of the population protected by social health protection (protected persons) by regions and selected countries, 2023 or latest year available (percentage)**



Note: Regional estimates are weighted by the total population. The figure represents the best estimate of people protected by a healthcare scheme for their primary coverage. Mechanisms include: national health insurance; social health insurance mandated by the State (including subsidized coverage for the poor); national healthcare services guaranteed for free or with small co-payments; and other programmes (such as user fee waivers and vouchers). For primary coverage, 202 schemes were identified and included in 2023. Only public or publicly-led healthcare schemes used as primary cover were included. Supplementary public and private programmes were not included. As data for Brunei Darussalam, Malaysia and Timor-Leste are unavailable, these countries were excluded from the weighted average calculations.

Source: ILO modelled estimates, 2024, World Social Protection Database, based on the Social Security Inquiry; ISSA Social Security Programs Throughout the World; ILOSTAT; national sources.

Some countries have been particularly proactive in pushing for registration of pregnant women under social health protection schemes. Notably, in the Philippines, the coverage of women about to give birth is prioritized under the Philhealth scheme, with specific mechanisms outlined under Philhealth circulars to ensure that women who are about to give birth are enrolled under the scheme so that they can avail of the benefit package.⁷

There is also a range of factors that contribute to gaps between legal and effective protection, many of which are similar to those outlined above for maternity cash benefits, particularly in relation to contributory schemes. Specific population groups tend to be disproportionately affected, including workers in the informal economy and their families, as well as migrant workers.

In turn, in some contexts, while coverage may appear universal, barriers to effective access may persist. For example, both in Indonesia and the Philippines, almost the entire population is registered with the respective health protection mechanisms, but many registered members are not up to date on their contributions, which negatively affects their entitlements under the scheme. For example, some 18.5 per cent of all enrollees in Indonesia's JKN scheme were recorded as inactive as of 31 October 2025 (Ministry of Health of the Republic of Indonesia 2025).

7 For more information, see: <https://www.philhealth.gov.ph/circulars/2015/circ025-2015.pdf>

Barriers may also result from the complexity of administrative procedures to access entitlements, or a lack of awareness of entitlements or mechanisms to access services (Bergthaller and Tessier 2025). In Lao PDR, for example, coverage by the National Health Insurance (NHI) scheme does not require any form of enrolment or registration, and successive surveys have highlighted large gaps in awareness of the scheme among the population: only 35.4 per cent of women and 34.3 per cent of men cited having knowledge of health insurance in the Lao Social Indicator Survey conducted in 2023 (Lao Statistics Bureau and UNICEF 2023). This lack of awareness may affect health-seeking behaviours. Similarly, access to covered services requires households to present their family book at health facilities, but only 15.4 per cent of children under one year of age are registered in the family book of their household (compared to 41.9 per cent of children under age 5), which may negatively affect their access of covered neonatal and child health services (ibid).

Paternity and parental benefits

There are no data at the global level to estimate the effective coverage of paternity and parental benefits. However, reliance on employer liability mechanisms in most contexts may result in very limited access to entitlements, including because these mechanisms de facto exclude self-employed workers, as well due to high rates of informal employment in many countries in ASEAN.

Singapore stands out as an exception, whereby paternity benefits are tax-financed. Here, the paternity benefits are paid by the employer and reimbursed by the Government. This may support effective access by removing the responsibility of employers to cover the costs thereof. In practice, however, data from 2023 indicates that only 56 per cent of eligible men took up their entitlements, while 74 per cent of women took up their entitlements to maternity cash benefits (Ministry of Social and Family Development of the Republic of Singapore 2025).

In turn, Singapore is the only country in ASEAN with statutory provisions for paid parental leave. At the global level, just under one third of countries provide statutory parental leave, mostly in Europe and Central Asia (Addati et al. 2022). Yet, paid parental leave plays an important role in supporting workers to reconcile care responsibilities and employment – especially in contexts where childcare services are not universally available – and in better distributing unpaid care work between parents.

Alignment in coverage between maternity cash and healthcare benefits

In contrast to maternity cash benefits, approaches to ensuring access to healthcare without financial hardship are typically (but not always) more unified, with universal legal coverage and concerted efforts to protect a wide share of the population – including through subsidized coverage of informal workers and vulnerable groups, either within a single mechanism or several highly complementary mechanisms. The fact that social health protection coverage is overall higher than coverage for maternity cash benefits is noteworthy. Given the strong complementarity between the two types of benefits in terms of supporting income, preventing poverty and addressing the social determinants of health equity, including for pregnant and lactating women, this disparity has implications for adequacy. There are also noteworthy missed opportunities to strengthen coordination and coherence in terms of efforts to extend coverage of maternity cash benefits along with extending health protection to enhance access.

There are many factors that contribute to these differences in coverage, the most significant of which being the manner in which they are financed. As outlined above, protection against the costs of accessing healthcare services is, in many contexts, partly subsidized by government general revenues. In contrast, non-contributory maternity cash benefits are very rare in the region, which instead are often an employer's liability or are guaranteed by social insurance mechanisms that struggle to extend coverage to workers in informal employment. These factors also contribute to great variations in terms of the institutional arrangements for the governance and administration of maternity cash benefits and social health protection across ASEAN.

In some contexts, a **single institution administers both maternity cash benefits and healthcare benefits**, including the National Social Security Fund (NSSF) in Cambodia, the Social Security Board (SSB) in Myanmar, the Social Security Office (SSO) in Thailand, and the Viet Nam Social Security (VSS) in Viet Nam. These schemes all target workers in the formal sector with informal workers covered on a voluntary basis, with the exception of VSS in Viet Nam, for which healthcare benefits are administered for the entire population.

In other contexts, the **governance and administration of cash benefits and health benefits is broadly separate**. For example, where countries operate national health services, as is the case in Brunei Darussalam, Malaysia, and Timor-Leste, the Ministry of Health is directly responsible for the delivery of services that are accessible for free or with minor fees at the point of service. Maternity cash benefits are governed and administered separately, remaining an employer's liability in Malaysia, combining employer liability with tax-financed mechanisms in Brunei Darussalam, and administered via the *Segurança Social* in Timor-Leste which covers only 2.2 per cent of pregnant and lactating women. Similarly, in Indonesia, while the JKN scheme achieves almost universal health protection coverage, maternity cash benefits continue to be an employer's liability. This may generate significant misalignment in coverage, particularly among workers in informal employment and self-employed workers, both of whom represent a dominant share of female employment in the country. In Singapore, health protection for citizens and permanent residents is guaranteed under various individual savings account schemes that cover services at different levels of care, and which achieve almost universal coverage, while maternity cash benefits continue to rely on employer liability mechanisms complemented by tax-financed reimbursements to employers.

Some countries have found ways to overcome this institutional fragmentation through **automatic affiliation and referral across schemes**. For example, in the Philippines, while the administration of health protection is separate from that of maternity cash benefits, all workers enrolled in the Social Security System (SSS) are automatically enrolled in the National Health Insurance Programme on a contributory basis, with their contributions to the scheme collected by the SSS and transferred to the National Health Insurance Programme for administration. The same applies to households included in the country's 4P cash transfer scheme,⁸ who are automatically enrolled on a non-contributory basis in the health insurance scheme. This automatic enrolment may reduce administrative barriers and facilitate access to the benefits that are relevant to maternity for covered groups. However, while the National Health Insurance Programme achieves almost universal coverage, including through the full or partial subsidization of contributions for informal workers and vulnerable groups, the SSS achieves only 14.6 per cent coverage of the population.

This situation has several implications in the region:

- Overall, the increase in social health protection coverage, including maternity care, experienced in ASEAN has not been used to extend maternity cash benefits, despite the strong complementarity between the two types of benefits, and their shared public health objectives. There is an untapped opportunity to build on the progress made when it comes to healthcare benefits to expend maternity cash benefits, in particular by moving away from employer liability provisions. In this context, achievements in expanding healthcare benefits can offer several lessons – including the importance of collective financing mechanisms to ensure effective coverage; the central role of general government budget allocations, including through fully or partially subsidizing contributions for groups with limited contributory capacity; and the mandatory rather than voluntary approach to extending coverage.
- There are also opportunities to better articulate and align the design and administration of maternity care and cash benefits. Where maternity cash benefits and health protection are administered separately, this may create administrative barriers to accessing these complementary benefits, especially where schemes operate under a different set of administrative procedures for members to register, enrol and claim benefits. Strengthening coordination and streamlining administrative processes and procedures could also contribute towards enhancing the user journey and facilitating access to complementary benefits.

8 The *Pantawid Pamilyang Pilipino* Programme (4P) provides households with health and nutrition grants.

Adequacy

This section reviews the adequacy of benefits afforded during maternity, including both cash benefits and healthcare benefits. It is important to highlight from the outset that in many contexts, there are differences in terms of entitlements between distinct categories of the population – including between public and private-sector workers, between different categories of covered members within schemes, between workers with different status in employment, and between citizens and non-nationals. These differences are highlighted below.

Maternity cash benefits

Duration and replacement rate of maternity cash benefits

Table 3 provides an overview of the legal entitlements for income replacement/continuity in case of maternity across ASEAN member countries. In almost all cases, the duration and replacement rates align with the minimum social security standards outlined in Convention No. 102. Several countries in the region extend the duration and replacement rate of maternity leave beyond the minimum requirements, aligning closer to Convention No. 183 and its accompanying Recommendation (No. 191). The most generous entitlements are found in Viet Nam, where covered members are entitled to six months of maternity cash benefits.

However, there are exceptions. For example, foreign workers in Brunei Darussalam and Singapore are entitled to eight weeks of paid maternity leave, which falls short of the minimum standards. In addition to differences in entitlements between groups based on citizenship, differences also exist between categories covered by mandatory social insurance and those covered on a voluntary basis (typically self-employed or informal workers), for example in Thailand and Viet Nam. In Thailand, self-employed persons covered by the voluntary scheme are not entitled to maternity benefits, but a child allowance of 200 Thai Baht (THB) – equivalent to US\$16 – per child is paid for up to two children under one of the “packages” that covered members select. In Viet Nam, women covered under the voluntary scheme are entitled to a lump sum payment equal to 2,000,000 Vietnamese Dong (VND) – equivalent to US\$76 – as opposed to periodic instalments. Maternity cash benefits under Cambodia and Myanmar’s social insurance schemes are also paid as a lump sum rather than in periodic instalments.

In addition, in Lao PDR, entitlements vary depending on the length of contributions. Women with at least nine months of contributions in the 12 months preceding childbirth are entitled to both maternity benefits and a maternity grant, while those with contributions of between six and nine months are entitled only to the maternity grant (see below).

► **Table 3: Replacement rate and duration of legal entitlements for paid maternity leave/maternity cash benefits**

Type and scope of legal entitlements		Duration of maternity leave	Level of income replacement
Countries with at least part of the entitlements provided through social protection			
Cambodia	Employer liability	90 days	50 per cent of reference monthly earnings
	Social insurance (private sector workers)	90 days	70 per cent of reference monthly earnings paid as a lump sum, with a minimum and maximum benefit

	Type and scope of legal entitlements	Duration of maternity leave	Level of income replacement
Lao PDR	Social insurance (private sector)	105 days, 120 days in case of birth of twins	80 per cent of reference monthly earnings
	Employer liability	105 days, 120 days in case of birth of twins	Remaining 20 per cent of reference monthly earnings
Myanmar	Social insurance (private sector)	14 weeks (18 weeks in case of the birth of twins)	70 per cent of reference monthly earnings
Philippines	Social insurance	105 days (with an additional 15 days for single parents)	100 per cent of reference monthly earnings
Singapore	Employer liability and tax-financed (Singapore citizens)	16 weeks	100 per cent of reference monthly earnings, up to a ceiling
	Employer liability and tax-financed (non-citizens)	12 weeks (8 weeks paid, 4 weeks unpaid)	100 per cent of reference monthly earnings
Thailand	Employer liability and social insurance (mandatory coverage for employees)	120 days (135 in case the newborns have medical complications)	100 per cent of reference monthly earnings for 120 days; 50 per cent for the additional 15 days
	Social insurance (voluntary scheme for self-employed workers)	Not applicable	Not applicable
Timor-Leste	Social insurance	12 weeks	100 per cent of reference monthly earnings
Viet Nam	Social insurance (mandatory scheme)	6 months (an additional month granted in case of multiple births)	100 per cent of reference monthly earnings
	Social insurance (voluntary scheme)	Not applicable	Lump sum allowance only
Countries reliant on employer liability only			
Brunei Darussalam	Employer liability (citizens and permanent resident workers)	13 weeks of the 15 weeks of maternity leave are paid	100 per cent of reference monthly earnings
	Employer liability (foreign workers)	8 weeks of the 9 weeks of maternity leave are paid	100 per cent of reference monthly earnings

	Type and scope of legal entitlements	Duration of maternity leave	Level of income replacement
Indonesia	Employer liability	3 months with possibility of extension to up to an additional 3 months in case of complications	100 per cent of reference monthly earnings during first 3 months; 75 per cent in case of extension
Malaysia	Employer liability	98 days	100 per cent of reference monthly earnings or rate prescribed by Ministry of Labour, whichever is higher

In some contexts, the amount of leave to be taken before or after the delivery is specified, but not in all cases. For example, of the 105 days of maternity leave in Lao PDR, at least 42 days must be taken after the birth, while in Myanmar, six of the 14 weeks of leave to which covered members are entitled to must be taken before the due date. Furthermore, in some cases, provisions are made for the duration of benefits to be extended in the event of complications faced by the mother or the newborn, as is the case in Thailand. Such provisions play a crucial role in enabling women who have given birth to fully recover or to care for their newborns who may face health complications, preventing premature returns to work. In contrast, women facing health issues requiring leave beyond the defined duration in Lao PDR must take sickness benefits covered by the country's social insurance scheme. The duration of maternity leave is extended in the event of multiple births in Lao PDR, Myanmar and Viet Nam, as proposed by Recommendation No. 191, to take account of the higher risk of pregnancy-related complications in such cases, the greater physiological strain of delivery, and the higher risk of premature births. This has implications for the health outcomes of newborns.

In Cambodia, Myanmar, Timor-Leste and Viet Nam, explicit provisions are made to grant dedicated paid leave for pregnant women to attend antenatal and postnatal care, distinct from the maternity leave and benefit entitlements, covered by the social insurance schemes. In Myanmar, women are entitled to up to seven days to attend prenatal examinations. In Viet Nam, pregnant women are entitled to two days for each prenatal check-up, for up to five check-ups, which is covered by the social insurance scheme. In Cambodia, women are entitled to an allowance of 80,000 Cambodian Riel (KHR) – equivalent to US\$20 – per antenatal visit, and for ten postnatal and newborn check-ups, paid for by the social insurance scheme. Meanwhile, in Thailand, in line with the Labour Protection Act, 98 days are granted to pregnant and lactating women, which includes leave required to attend check-ups before delivery. The country's social insurance scheme also provides reimbursements to covered members for antenatal care expenses, up to a maximum of THB1,500 (equivalent to US\$46). These types of provisions reinforce the coherence between maternity cash benefits and access to healthcare services. By removing the potential opportunity cost of accessing these crucial services, such provisions can support in promoting effective uptake, which contributes significantly to positive health outcomes. More research would be required to better understand provisions for paid time off to attend these types of services in other countries.

In some contexts, specific provisions are also made in cases of stillbirths or miscarriages, as well as for intended mothers in the case of adoption. Such provisions allow for physical and psychological recovery after miscarriages and stillbirths. In the case of adoptions, provisions are important to enable intended parents to bond with their adopted child and provide the necessary care. The table below summarizes entitlements in these cases, where provisions are explicitly identified.

► Table 4: Provisions in case of miscarriage, stillbirth or adoption, where identified

		Entitlements in case of miscarriage	Entitlements in case of stillbirth	Entitlements in case of adoption
Brunei Darussalam	Employer liability (citizens and permanent residents)	8 weeks of paid leave in the event of miscarriage at or after 24 weeks of gestation	8 weeks of paid leave in the event of miscarriage at or after 24 weeks of gestation	No provisions identified
	Employer liability (foreign workers)	No provisions identified	No provisions identified	No provisions identified
Cambodia	Employer liability	No provisions identified	No provisions identified	No provisions identified
	NSSF members	KHR80,000 is paid in case of miscarriage before 24 weeks	Same lump sum cash benefit applies as in case of live birth	No provisions identified
Indonesia	Employer liability	1.5 months of paid leave	No provisions identified	No provisions identified
Lao PDR	Social insurance (private sector)	Same entitlements as live birth in case of miscarriage after 6 months of pregnancy	Same entitlements as live birth	Same entitlements as birth mothers in case of adoption of a child under 3 months of age
Malaysia	Employer liability	No provisions identified	No provisions identified	No provisions identified
Myanmar	Social insurance (private sector)	6 weeks of paid maternity leave	No provisions identified	8 weeks of paid maternity leave in case of adoption of a child under 1 year
Philippines	Social insurance	60 days of paid leave granted for miscarriage or emergency termination	No provisions identified	No provisions identified

		Entitlements in case of miscarriage	Entitlements in case of stillbirth	Entitlements in case of adoption
Singapore	Employerliability and tax-financed (Singapore citizens)	No provisions identified	Same entitlements as live birth	12 weeks of paid maternity leave
	Employerliability and tax-financed (non-citizens)	No provisions identified	No provisions identified	No provisions identified
Thailand	Employerliability and social insurance (mandatory coverage for employees)	No provisions identified	No provisions identified	No provisions identified
Timor-Leste	Social insurance	4 weeks of paid leave in case of termination of pregnancy	No provisions identified	Same entitlements as birth mothers
Viet Nam	Social insurance (mandatory scheme)	Between 10 and 50 days of paid leave paid at 100 per cent of the monthly allowance divided by 24 or 30 depending on cases	Between 10 and 50 days of paid leave paid at 100 per cent of the monthly allowance divided by 24 or 30 depending on cases	Same entitlements as birth mothers
	Social insurance (voluntary scheme)	Same entitlement as live birth	Same entitlement as live birth	Same entitlement as birth mothers

Birth grants

In seven out of the 11 ASEAN Member States, birth grants were identified, which are provided to new parents in addition to maternity cash benefits. Such grants play an important role in supporting families with the additional expenses of welcoming a newborn (or multiple newborns), which could otherwise impose a burden on families. Table 5 provides an overview of the level of birth grants identified in ASEAN Member States and their financing arrangements.

In contexts in which paid maternity leave is exclusively reliant on employer liability, as is the case in Indonesia and Malaysia, no provisions were identified. In contexts in which maternity cash benefits are guaranteed under social insurance mechanisms (whether in part or in full), such mechanisms provide birth grants, which are often (but not always) calculated as a share of reference monthly earnings. In Lao PDR and Thailand, the birth grant is either paid to a covered member giving birth, or to the wife of a covered member, if the wife is not insured herself.

In Brunei Darussalam and Singapore, universal birth grants are financed through the general government budget: in Brunei Darussalam, these cover newborns who are citizens or permanent residents, or newborns whose mothers are citizens, while in Singapore these benefits cover Singaporean newborns only. In both countries,

the grants are paid into a savings account opened on behalf of the child to encourage parents to save for their children to meet immediate- and medium-term expenses. Both in Brunei Darussalam and Singapore, these birth grants can be used for specified purchases only, whereas there are no restrictions on the usage of birth grants where they have been identified in the other contexts.

In most of the countries where a birth grant has been identified, a unique benefit is applied to all newborns, while in Cambodia and Myanmar, the value of the birth grant is increased in the event of multiple births, in order to account for the related additional costs. In Singapore, the value of the benefit increases in line with birth order, and the value of the benefit is being progressively increased over time, with the objective of enhancing fertility rates in a context of demographic change.

► **Table 5: Provisions for birth grants**

	Financing	Eligibility	Benefit value
Brunei Darussalam	Tax-financed (Skim Tabungan Anak Damit scheme) ¹⁰	Children who have Bruneian citizenship, permanent residents with no other citizenship, or foreign nationals, whose mothers are Brunei citizens or stateless	One-time payment of BN\$240 per child (equivalent to US\$187)
Cambodia	Social insurance	Covered members	Lump sum payment of 50 per cent of reference monthly earnings (70 per cent in the event of the birth of twins, 100 per cent in the event of the birth of triplets or more)
Indonesia	No provisions identified	N/A	
Lao PDR	Social insurance	Covered members or wife of covered member	Lump sum payment of 60 per cent of reference monthly earnings
Malaysia	No provisions identified	N/A	
Myanmar	Social insurance	Covered members	Lump sum payment of 50 per cent of reference monthly earnings (75 per cent in the event of the birth of twins; 100 per cent in the event of the birth of triplets or more)
Philippines	No provisions identified	N/A	
Singapore	Tax-financed (Child Development Account)	Singaporean children	Child Development Account: S\$5,000 (equivalent to US\$3,915) per child for the first two children and S\$10,000 (equivalent to US\$7,830) per child for subsequent children. The Government also matches any savings made in the account, up to a ceiling

10 This scheme was introduced on 1 May 2026. For more information, see: https://www.mofe.gov.bn/2026/02/24/pr_24022026_skimtabungananakdamit/

	Financing	Eligibility	Benefit value
Thailand	Social insurance (mandatory scheme)	Covered members or wife of covered member	THB15,000 per child (equivalent to US\$468.3)
Timor-Leste	No provisions identified	N/A	
Viet Nam	Social insurance (mandatory scheme)	Covered members	VND4,680,000 (equivalent to US\$178)

Means-tested cash transfer schemes

As noted in the previous chapter, some countries in the region also implement **non-contributory cash transfer** programmes (usually means-tested) to support income and alleviate poverty, including for pregnant and lactating women. As highlighted above, there are significant differences between these schemes in terms of the target populations and coverage, but also in terms of the value of the benefit and whether these are a periodic or lump sum payments, as outlined below.

- **Cambodia:** under the cash transfer scheme covering vulnerable households, identified through the the Identification of Poor Households Programme (IDPoor), the design is similar to the grants and allowances paid by the National Social Security Fund (NSSF). Women covered by the cash transfer scheme are entitled to KHR40,000 (equivalent to US\$10) for each antenatal visit, including up to four visits; KHR200,000 (equivalent to US\$50) for the delivery; and KHR40,000 (equivalent to US\$10) per postnatal check-up for the mother or child, including up to ten check-ups.
- **Indonesia:** under the programme *Keluarga Harapan* (PKH), pregnant mothers and children under six years of age receive a payment of 3,000,000 Indonesian Rupiah (IDR) – equivalent to US\$177 – per year, which is paid quarterly. Payment is conditional on compliance with specific terms, requiring pregnant mothers to attend regular health checks and give birth at a health facility, and children under six years of age to attend routine health monitoring visits, including immunizations.
- **Lao PDR:** under the Helping Hands Programme, eligible households receive a monthly cash benefit of 180,000 Laotian Kip (LAK) – equivalent to US\$8.4 – per month, which is paid every two months. The payment is conditional on meeting meet health and nutrition requirements, including attending at least four antenatal care visits and health and nutrition behavioural change sessions, as well as immunizations.
- **Malaysia:** different programmes operate in different states across Malaysia. For example, under the *Mamakerja* scheme implemented in Selangor State, eligible working mothers with children aged six years and below receive a monthly cash transfer of 100 Malaysian Ringgit (RM) – equivalent to US\$25 – for one year, providing ongoing support for childcare costs while promoting women's labour force participation and economic security. In Sarawak, the *Bantuan Ibu Bersalin* programme provides a fixed cash grant of RM450 (equivalent to US\$114) to mothers after childbirth regardless of socio-economic status. In Kedah, the *PermartaKu Sejahtera* programme provides a one-off cash grant of RM200 (equivalent to US\$50) for each newborn. In Pahang, the *Pernyata Makmur* provides a RM250 (equivalent to US\$63), deposited into the child's savings account along with a baby supplies voucher valued at RM50 (equivalent to US\$12).
- **Myanmar:** the Maternal and Child Cash Transfer (MCCT) programme, implemented in certain regions by the Ministry of Social Welfare Relief and Resettlement, provides a monthly cash transfer of 15,000 Myanmar Kyat (MMK) – equivalent to US\$7.2 – per month to pregnant and lactating women up to when their child reaches 24 months.

- **Philippines:** the *Pantawid Pamilyang Pilipino* Programme (4P) provides a health and nutrition grant of 750 Philippine Peso (PHP) – equivalent to US\$12 – per month per household for 12 months per year, which is paid every two months.
- **Timor-Leste:** under the *Subsídio de Apoio Pontual aos Vulneráveis*, support is provided both in cash and in kind, with the financial assistance taking the form of a one-off cash transfer of up to US\$2,000 per year. A new programme is also being introduced in 2026.

While these programmes provide some level of support to vulnerable families to meet basic needs and access necessary services, including for their children, their adequacy is often constrained by the available resources allocated to them.

Healthcare benefits during maternity

In order to assess the adequacy of healthcare benefits for maternity, the following dimensions (see chapter 2) need to be considered:

- The comprehensiveness of the benefit package for healthcare benefits in case of maternity in the legal and policy framework, as well as in practice, in terms of availability and access within the network of healthcare providers identified to deliver the benefit package; and
- The level of financial protection that is afforded by law and policy for accessing the benefit package and the effective level of financial protection (or lack thereof) in practice.

Entitlements and effective access to RMNCH services

Legal entitlements

The review of legal and policy frameworks for the social health protection schemes outlined above (see coverage section) reveals that in each country, the schemes used for primary coverage include elements of maternity care, particularly regarding delivery. While this holds true, it is difficult to determine whether the benefit packages for maternity care under social health protection schemes are comprehensive. This is because in many countries in ASEAN, such benefit packages are not explicitly defined or are defined in very broad terms. In Brunei Darussalam, for example, the benefit package is implicit to a large extent, and in Myanmar the SSS includes broad and somewhat vague provisions for maternity care. In some contexts, the benefit packages of certain schemes are not set in national legal or regulatory frameworks, but rather a range of policy documents and guidelines, as is the case for the Health Equity Fund in Cambodia. This further complicates their identification, and comparability across schemes.

Overall the following can be identified:

- **In countries where different schemes coexist for social health protection, each scheme tends to provide slightly different entitlements, or those that can be formulated differently.** In Cambodia, for example, the NSSF benefits related to maternal, neonatal and child health are defined in relatively broad terms (such as delivery and pre- and postnatal services), while the minimum package of the Health Equity Fund covers “mother, newborn, child, and reproductive health services, including prenatal care, delivery, or postnatal care by primary or secondary midwives certified by the MoH, as well as drugs included on the essential drugs list.” The supplementary package includes surgery, gynecology and obstetrics services, pediatrics, laboratory tests, specialized services and imagery.
- **In countries where different schemes coexist for social health protection, entitlements can often be availed in different networks of healthcare providers or with slightly different entitlements.** For example, access to private providers is usually more limited in national health service systems and in non-contributory schemes, and contributory mechanisms tend to provide some enhancements, such as private rooms in case of hospitalization for delivery. In the case of Cambodia, the HEF covers services in

public facilities only; the NSSF covers services mainly in public facilities, with the exception of with private facilities in certain manufacturing zones, including to deliver reproductive and maternity services, given the dominant share of women in NSSF membership.

- **Some countries with different coexisting schemes have made efforts to align packages for maternity care.** In Lao PDR, a nationally defined RMNCH package was operationalized in 2013 and further integrated within the NHI scheme in 2016/2017. The NHI and the Lao Social Security Organization (LSSO) cover the same benefit package, which includes outpatient and inpatient care, including RMNCH, with exclusions limited to services covered by vertical programmes, elective or VIP services. In Thailand, the benefit packages under different schemes are relatively harmonized, all covering access to antenatal and postnatal care and delivery care, as well as necessary check-ups and treatments – including for newborns – and access to medicines included in the National List of Essential Medicines. The benefit package of the Migrant Health Insurance Scheme (MHIS) is relatively less comprehensive but includes maternity and neonatal care, as well as immunizations for children under age five.
- **Overall, most schemes clearly define the inclusion of pre-and postnatal checks as well as delivery and newborn care, yet some schemes are more precise than others.** In Indonesia, the JKN scheme covers a comprehensive set of maternal and neonatal care services, including six antenatal visits, essential medicines, delivery care, ultrasounds and four postnatal visits. Meanwhile, in Singapore, the MediShield Life scheme, which provides coverage against catastrophic expenditures, provides explicit coverage for 24 types of complications related to pregnancy and delivery.
- Similarly, **some schemes have explicit exclusions**, which can sometimes relate to preventive care that is deemed to be covered through general prevention care, managed centrally by the Ministry of Health (see section below on networks of service providers). In Viet Nam, while the benefit package of the VSS is relatively comprehensive in relation to maternal, neonatal and child health, explicit exclusions include prenatal tests and diagnoses for non-treatment purposes, as well as family planning. Some schemes specify the coverage of care in case of miscarriage and during the first year of the child's life, as is the case for the SSS in Myanmar.

It is worth noting that in several contexts, services for maternity and newborn care have been prioritized in the benefit package design of the health protection schemes, and specific regulations apply thereto. In the Philippines, the NHI programme includes a maternity care package and a newborn care package that cover all the essential services required for women about to give birth and for newborns during the first hours of life, aiming to ensure financial access to services that promote survival and well-being. Similarly, Malaysia gave high priority to maternal and child health in its national health service at an early stage. This prioritization effectively yielded results, with practically all births (99.4 per cent) in Malaysia attended by skilled healthcare staff in 2015 (World Bank 2020). Moreover, maternal and neonatal disorders fell from the third leading cause of premature deaths in the country in 1990 to ninth place in 2017 (Noor et al. 2020). The removal of financial barriers was identified as playing a crucial role in these achievements (Pathmanathan et al. 2003).

It is also important to consider the coverage of **indirect costs** of accessing healthcare and adhering to medical recommendations. For example, nutrition is essential during maternity, which comes at a cost, as does transportation to health facilities. In most contexts, transport for referrals between facilities in case of emergencies are covered, except in Singapore, where ambulance services are not eligible for reimbursement under the schemes. Yet, limited information is available on the extent to which schemes also support transportation costs from home to the nearest primary healthcare contact point and in non-emergency situations. A few examples were identified, including under the HEF in Cambodia, where a transportation allowance is provided to cover members' transportation costs in case of deliveries. The scheme also provides a caretaker food allowance. Similarly, the NHI in Lao PDR provides a transportation and food allowance during hospitalization and covers the costs of referrals between hospitals in emergencies, but these are only covered for those identified as vulnerable. In most other contexts, meals are included as part of inpatient services.

Network of service providers

The **mix of public and private providers** included in the network of social health protection schemes varies:

- In the case of national health services – as operating in Brunei Darussalam, Malaysia and Timor-Leste – services are covered in public hospitals, with only some exceptions for coverage in private facilities.
- Some national and social health insurance schemes also predominantly cover care in public facilities, including in Lao PDR.
- In other contexts, where the health systems are pluralistic with a relatively strong private health sector, a mix of public and private facilities are contracted, including in Indonesia, the Philippines, Thailand, Singapore and Viet Nam (depending on the scheme).

In addition, **specialized** facilities (whether hospitals or clinics) delivering maternal and newborn care are included in the network of service providers in Malaysia, Lao PDR (in Vientiane Capital) and Timor-Leste. Such specialization can improve the quality of care and health outcomes, while also reducing the utilization of general hospitals, allowing these facilities to focus on other health needs. However, this approach may undermine the continuity of care, particularly for patients with co-morbidities, and these types of specialized facilities are typically concentrated in urban areas.

In certain contexts, specific efforts are made to account for regional differences in **accessibility** to services. For example, in the Philippines, where over 3,000 public and private health facilities are accredited to provide the country's maternity care package, only low-risk standard vaginal deliveries are compensated in non-hospital facilities, while diagnosis of any conditions or factors that may place the pregnancy at risk of complications must be referred to a hospital. Exceptions are made, however, for services delivered in areas identified as geographically isolated and disadvantaged, where access to hospitals is limited.¹¹

Furthermore, in certain contexts, specific efforts are made to expand **health promotion and prevention** interventions with a focus on populations residing in remote areas, which may include a strong focus on maternal counselling and support. Such programmes are often delivered through the Ministry of Health for the entire population free of charge. In Timor-Leste, the *Serviço Integrado de Saúde Comunitária* programme seeks to bring essential health services closer to communities by delivering a basic package of services to each village on a monthly basis. Under the programme, a proactive approach is adopted to identify pregnant women within communities and encourage their uptake of antenatal care, as well women who have recently given birth and may require postnatal follow-up care, including home visits if needed (UN et al. 2018). Similarly, village health volunteers in Lao PDR provide counselling about reproductive, maternal, newborn and child health, and support timely referral to health facilities when relevant.

In addition to the services covered by existing social health protection schemes, **non-governmental organizations** (NGOs) play a role in the delivery of RMNCH services in certain contexts, including in Lao PDR and Timor Leste, where they operate health facilities that deliver healthcare in specific areas, or for specific services. Such services are usually provided with very low or no user fees, with a strong focus on underserved communities.

Effective availability and utilization of services

Analysis of global trends related to the subindices of SDG target 3.8.1 on RMNCH (encompassing family planning, antenatal care, DTP3 immunization and Acute Respiratory Infection care seeking) shows there was slow progress in terms of the availability of such services from 2000-2021 (WHO and World Bank 2023). The average annual changes have been below 1 per cent since 2000 and no changes have been observed since 2015 (ILO 2024a).

An analysis of the subindex for ASEAN countries reveals an uneven picture (figure 10). It is worth noting that some countries do not have data points for several of the components of the index. In particular, only three countries monitor antenatal care visits in a comparable way,¹² and in some countries there are gaps in monitoring coverage

11 For more information, see <https://www.philhealth.gov.ph/circulars/2015/circ025-2015.pdf>

12 Share of women aged 15-49 years with a live birth in a given time period who received antenatal care four or more times.

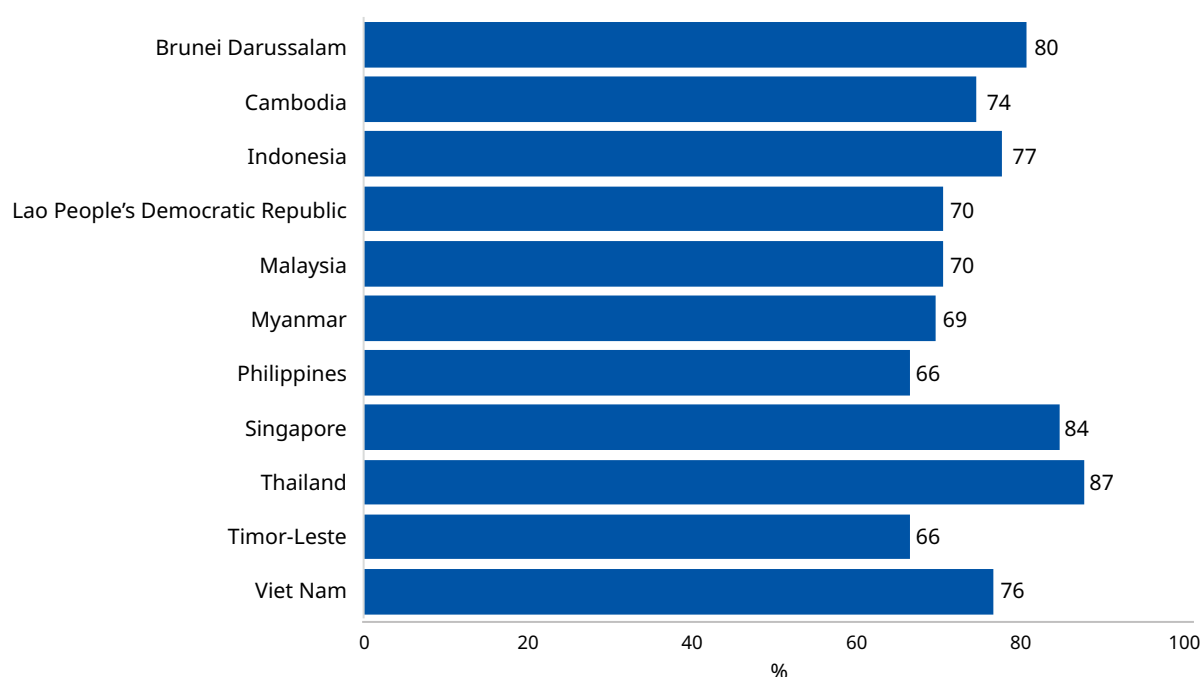
of national cervical screening programmes and demand for family planning in line with modern methods (SDG target indicator 3.7.1). Regarding the latter, it is important to underline the centrality of sexual and reproductive rights and services when discussing maternity (Razavi et al. 2024; ILO 2026b). In this context, access to affordable and good quality services related to sexual and reproductive rights is critical to ensuring that women are able to freely determine the number of children they want to have, and at what intervals, reducing their risk of carrying the social, economic and health consequences of unwanted pregnancies or unsafe abortions (Folbre 2021).

Overall, ASEAN Member States made efforts to meet the Millenium Development Goal targets, and both their monitoring and performance in this respect are better than for the indicators that were later added under the SDG framework. All indicators for which data are available show some correlation between country income level and performance. Yet there are some countries with limited resources, such as Lao PDR, which have clearly prioritized many components of RMNCH and their monitoring. Differences tend to be less marked regarding infant immunization than for other available indicators.

It is important to note that some healthcare services that contribute to a safe and healthy maternity experience are not necessarily captured by the UHC service coverage index, including some services that tend to be less developed and accessible in resource-poor settings. For instance, there is evidence that access to mental health services for prevention, detection and treatment of post-partum depression remain very unequal in ASEAN countries (Hong and Buntup 2023).

Similarly, it is important to analyze who is accessing RMNCH services and how utilization may vary across population groups of different socio-economic backgrounds and those residing in different locations. In this respect, available evidence shows that ASEAN countries have made progress in reducing inequalities when it comes to access to maternal and child health (MCH) services, but inequalities persist (Feng et al. 2023). Research shows that while Thailand and Viet Nam have reduced inequities in utilization, efforts in other countries tend to have privileged specific geographic areas or benefited groups of the population that are better off (Feng et al. 2023).

► **Figure 10: UHC Service Coverage subindex on reproductive, maternal, newborn and child health, by selected countries, latest year available (percentages)**



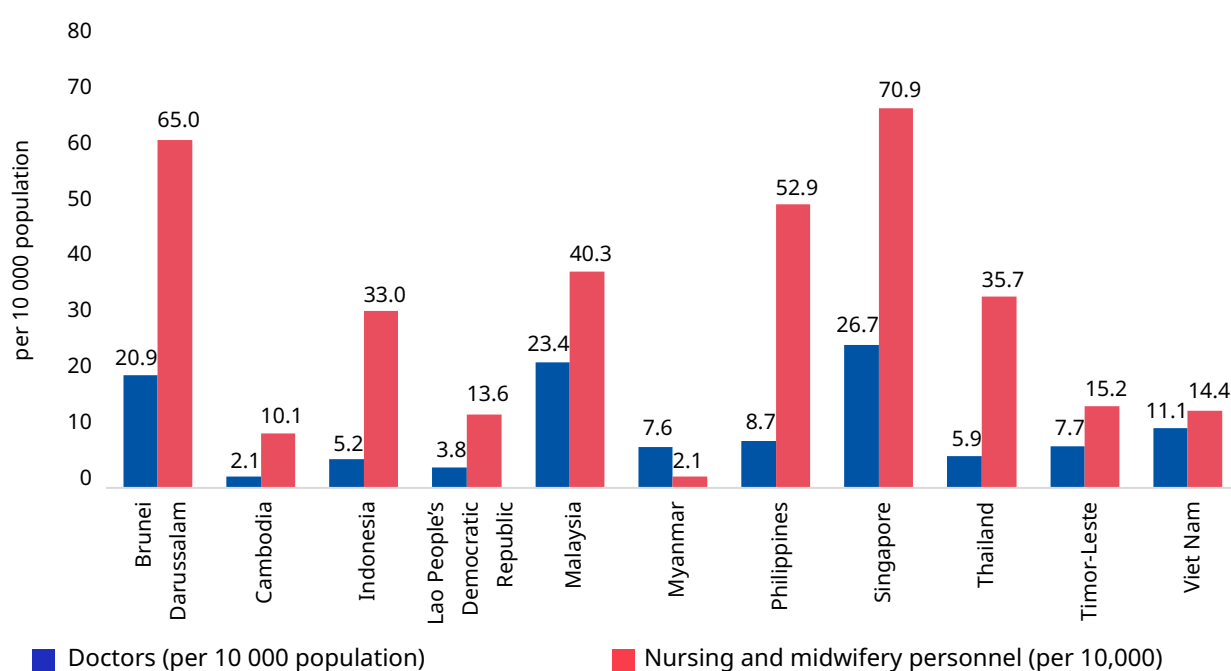
Source: Based on data from the WHO Global Health Observatory.

Access to RMNCH services without hardship is enabled by the recognition of the right to social health protection, but to be effective it also requires the provision of these services in a way that guarantees their availability, acceptability, adaptability and quality. This requires a broader enabling framework within the health system and beyond, encompassing free birth registration, adequate policy and regulatory frameworks, effectively implemented medical guidelines in line with WHO recommendations, as well as well-equipped and staffed facilities near women's homes and workplaces (WHO, n.d.). Studies on utilization of MCH services at the primary care level have highlighted that low utilization correlates with both low socio-economic status and disparities in healthcare provision (Herwansyah et al. 2022). In this context, the need to invest in primary care is central, and efforts to ensure acceptability of services for a range of population groups, including women from ethnic minorities, is equally important in ASEAN Member States (Liabsuetrakul 2022).

In this regard, the availability and retention of well-trained health professionals able to provide RMNCH services is crucial and requires that such staff can access lifelong training opportunities, certification for their competencies, support in their daily work, and more broadly, that they can enjoy decent work. In this respect, ASEAN Member States have made different choices in terms of the level of recognition afforded to midwifery, the status and engagement of community health workers, as well as the overall staff mix across nurses, midwives and doctors. Figure 11 illustrates some of these differences and the unequal investments countries have made in their nursing and midwifery workforce.

The State of Asia's Midwifery 2024 report highlights shortages of midwives in Lao PDR, Myanmar, Timor-Leste and Viet Nam (UNFPA 2025). It has been outlined in a number of studies that the distribution and the nature of human resources deployed for maternity care in health facilities plays a role in the effectiveness of financial protection of women giving birth. Without qualified personnel at the nearest point of care, additional costs related to transportation and overnight stays away from home, or care sought without financial protection in private health facilities near home are incurred (Nagpal et al. 2019).

► **Figure 11: Density of nurses, midwives and doctors in ASEAN Member States, latest year available**



Note: Data refer to the latest year available, which varies by country and indicator. Doctors data range from 2019 to 2024; nurses and midwives data range from 2017 to 2024. Nurses and midwives are presented as a combined indicator.

Source: Based on data from the World Health Organization (WHO), 2026, Global Health Observatory, health workforce indicators.

Financial protection against healthcare costs during maternity and unmet needs

The adequacy of social health protection is also determined by official cost-sharing arrangements and their effective enforcement in practice. As noted in chapter 2, ILO standards do not foresee cost-sharing for maternity care. This is particularly important, since an analysis of a subset of 78-89 countries¹³ for which disaggregated data are available shows that there is a striking social gradient in access to RMNCH services – in particular, there is a difference of almost 15 percentage points between highest (median coverage of 73 per cent) and lowest wealth quintiles (58 per cent), and an overall difference of 3-4 percentage points between each quintile. There are also inequalities between urban (70 per cent) and rural (63 per cent) populations and between those with no education (56 per cent) and those with secondary or higher education (71 per cent) (WHO and World Bank 2023).

The situation varies across ASEAN Member States:

- There are a few contexts in which **no form of co-payment** is applied to covered members, regardless of the type of service accessed, including but not limited to maternity care. These include the NSSF and Health Equity Fund schemes in Cambodia, the JKN scheme in Indonesia, and the national health service in Timor-Leste.
- In Viet Nam, there are **different levels of co-payments applied to different categories of members** under the VSS, and the type of health facility at which care was sought. Here, co-payments are waived for members of poor households, ethnic minority groups, children under the age of six, those identified as persons of merit, and social assistance recipients, while co-payments ranging between 5 and 20 per cent of eligible treatment costs apply for other categories of covered members.
- In Lao PDR, Myanmar and Thailand, where multiple schemes operate, there are **differences between schemes in terms of the official levels of financial protection afforded**. In Myanmar, no co-payments apply when accessing services for members covered by the SSB scheme. For the majority of the population (which is not covered by the scheme), services can be accessed at public health facilities for a limited user fee. In Thailand, while the benefit package is broadly similar across schemes (except for the MHIS, covering migrants), the levels of financial protection afforded vary. Here, no co-payments are applied to members of the SSS scheme, while a small co-payment is applied under the Civil Servant Medical Benefit Scheme (CMBS). Under the country's Universal Coverage Scheme (UCS), a charge of THB30 (equivalent to US\$1) is applied for patients requiring prescription medicine, only. Under the MHIS, a co-payment of THB30 (equivalent to US\$1) is applied when accessing healthcare services, with no exceptions for maternity services. This scheme only covers a combined total of THB10,300 (equivalent to US\$321) for antenatal care, family planning and contraceptives, and delivery costs, with any excess to be borne by the patient. Finally, in Lao PDR, access to maternal, neonatal and child health has historically been exempt from co-payments, but these were introduced for all services under the NHI following reforms adopted in 2024. Only LSSO members and those identified as poor are exempt. Co-payments range from LAK10,000-80,000 (equivalent to US\$0.46-2.8) for outpatient consultations (depending on the type of facility), while co-payments for vaginal deliveries range from LAK30,000-200,000 (equivalent to US\$1.4-9.4), and those for caesarean sections range from LAK500,000-800,000 (equivalent to US\$23-37).
- **Differences in cost-sharing arrangements by citizenship/residency status** apply in Brunei Darussalam, where maternal, neonatal and child health services are provided through the national health service scheme, which covers citizens and permanent residents. Certain maternal and neonatal health services are provided free of charge to all mothers, regardless of nationality or migration status, including antenatal and postnatal care, medicines and essential MCH services. However, fees apply for permanent residents and foreign workers for other types of outpatient consultations, as well as deliveries and ward charges. Employers of foreign workers are required to purchase private medical insurance on their behalf, which could cover these co-payments. Nevertheless, financial risks may arise where total expenses associated with surgery or complicated deliveries exceed insurance coverage limits, or where specific services are excluded under the employer-selected insurance policy.

¹³ The number of countries depends on the disaggregation.

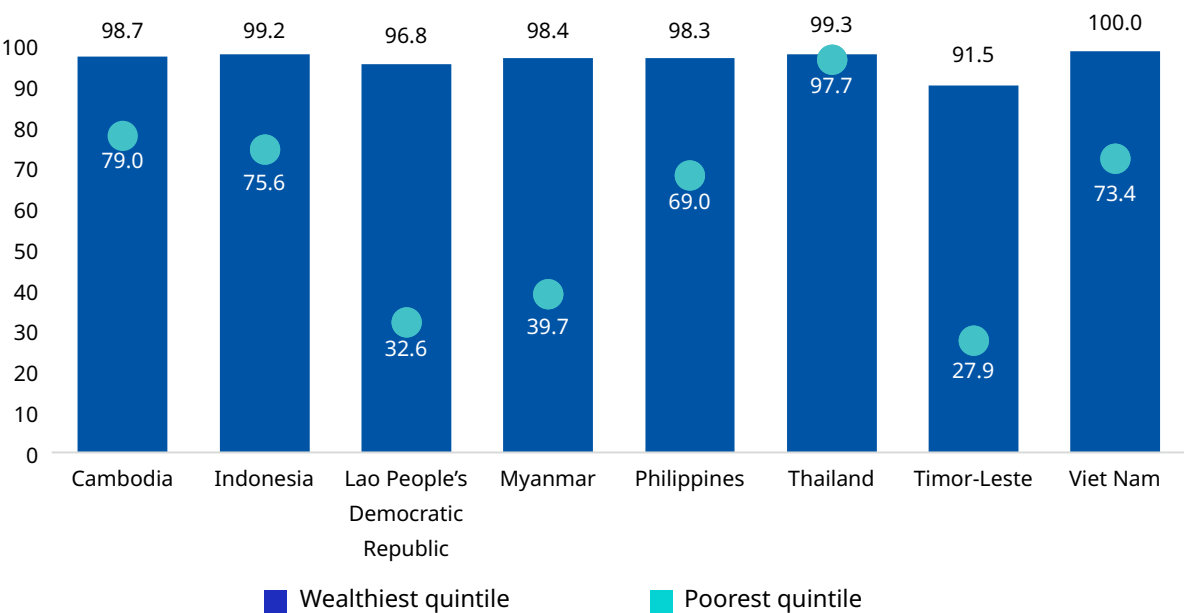
- In Singapore and Malaysia, **some form of co-payment applies to all categories of the population**, regardless of the types of services accessed, including RMNCH. Under the savings account schemes that operate in Singapore, specific ceilings are applied to the withdrawals that can be made under the accounts for different types of services. The ceilings applied under the MediSave Maternity Package are higher than for other types of services. Any charges that apply above these ceilings may be covered by the MediShield account. The level of financial protection afforded therefore depends on the amount of savings accrued in the individual accounts, as well as the ceilings that apply for withdrawals, which provides little predictability to pregnant women in terms of financial protection. In Malaysia, under the national health service, a nominal fee is applied when accessing services, with no exceptions for maternal, neonatal and child health services. Fees range from MYR1 (equivalent to US\$0.25) for pre- and postnatal check-ups, and MYR50 (equivalent to US\$5) for postnatal care provided by a midwife. For deliveries, the fee depends on the class of the ward, as well as the method of delivery, ranging from MYR10 (equivalent to US\$2.5) for ordinary delivery in a third-class ward to MYR1,200 (equivalent to US\$305) for a caesarean section in a first-class ward.
- Some countries do not have co-payments, but allow for balance billing – a situation in which healthcare providers can require patients to pay the difference between the agreed tariff under the national health insurance and the actual price the facility wants to apply. In the Philippines, while balance billing is authorized under the NHI scheme (with exemptions for vulnerable groups of the population), a no-balance billing policy applies to the maternity care and newborn care packages when accessing care in public and private maternity clinics and birthing homes, covering all compensable services allowed in accredited facilities (Article 8 under General Guidelines).¹⁴

Thus, in most contexts in ASEAN, some official cost-sharing arrangements apply when accessing maternal, neonatal and child health services, whether for all or for specific categories of the population. The persistence of these official co-payments may affect health seeking behaviours, represent a financial barrier to access, or in the worst case, cause catastrophic out-of-pocket health expenditures. Beyond official co-payments, out-of-pocket expenditures when accessing RMNCH services may also result from a number of other factors. These include, for example: limitations to the benefit package covered under respective schemes; limitations to the accessibility of the network of service providers, which may cause people to seek care outside of the designated network and therefore pay out of pocket; and inadequate provider payment rates that may drive informal payments.

For vulnerable households, even nominal fees can act as a deterrent, leading to delayed care-seeking behaviour. This delay is particularly hazardous in the context of maternal and neonatal health, whereby complications can escalate rapidly. Furthermore, these costs may drive regressive financing outcomes, as the poorest quintiles of the population spend a disproportionately higher share of their income on essential services compared to wealthier groups. This translates into a social gradient in access to some maternity care services in ASEAN countries (figure 12). For these reasons, international social security standards call for RMNCH services to be accessed free at the point of use.

14 <https://www.philhealth.gov.ph/circulars/2015/circ025-2015.pdf>

► **Figure 12: Share of live births attended by skilled health personnel by wealth quintile, selected countries by region, 2019 or latest available data (percentage)**



Note: Data are not available for Brunei Darussalam, Malaysia, and Singapore.
Source: Based on data from the WHO Global Health Observatory.

Eventually, financial barriers drive behaviours that lead people to forgo care. Some preventive services are particularly affected by these behaviours, as people tend to delay or forgo their use when they do not correspond to an acute need, particularly if the financial barriers are too high. Women, particularly those in lower socio-economic categories of the population, are the most affected by this, as the decision to seek care may not pertain entirely to them, and may be part of broader trade-offs arbitrated by the head of the household (Razavi et al. 2024; ILO 2026b). Globally, analysis of available data for 58 countries shows that an inability to pay for health services is cited as a reason for forgoing care among women aged 15-49 years of age across the household income spectrum. The pattern follows a clear social gradient, with over 65 per cent of women in the lowest income quintile citing this explanation, compared with around 30 per cent of women in the richest quintile (WHO and World Bank 2023).

Paternity and parental leave and benefit entitlements

The table below summarizes the duration and income replacement levels of paternity cash benefits and parental leave benefits, where these apply. As can be seen, the duration of paid paternity leave varies significantly across ASEAN Member States, from two days in Indonesia to four weeks in Singapore. As highlighted above, in the case of Cambodia and Lao PDR, labour laws do not specify the right to dedicated paternity leave. Instead, workers are entitled to a defined amount of fully paid “personal leave” or “special leave” per year, covered by the employer, which covers a range of contingencies that affect the family of the worker, including the birth of a child (and a miscarriage, in the case of Lao PDR).

► Table 6: Provisions for income replacement during paternity and parental leave

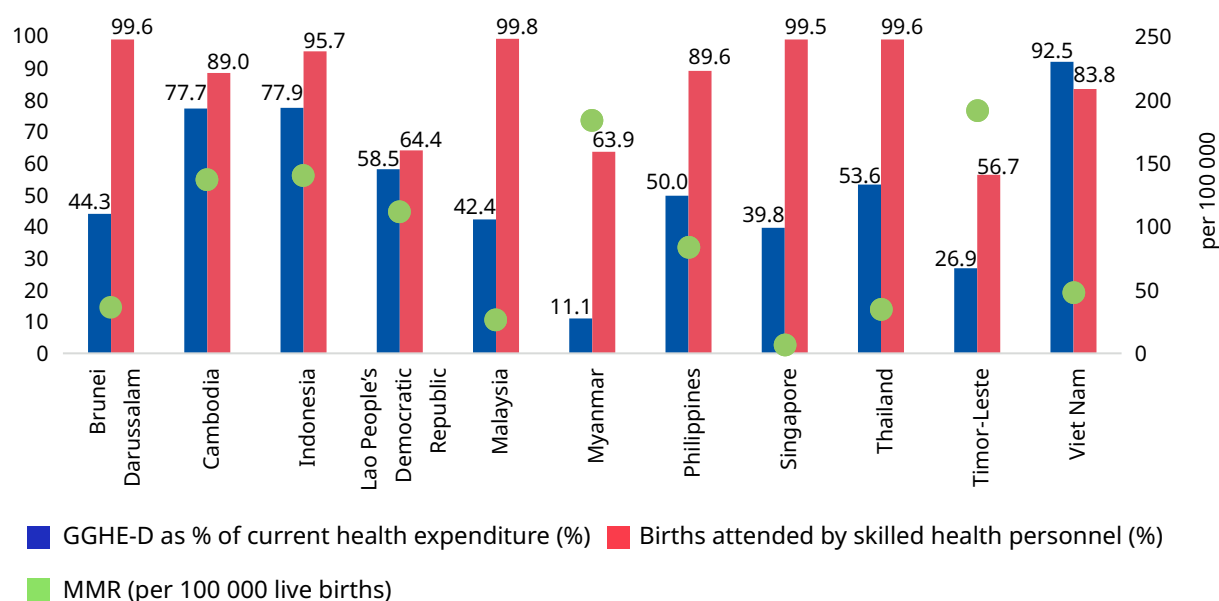
	Source of financing	Duration	Replacement rate	Parental leave entitlements
Countries with entitlements at least partially provided through social protection				
Myanmar	Social insurance	15 days	70 per cent of reference earnings	No provisions identified
Singapore	Tax-financed	4 weeks	100 per cent of reference earnings (up to a ceiling)	6 weeks, up to S\$2,500 per week
Timor-Leste	Social insurance	5 days	100 per cent of reference earnings	No provisions identified
Viet Nam	Social insurance	5 days with possibility of extension	100 per cent of reference earnings	No provisions identified
Countries reliant on employer liability only				
Cambodia	Employer liability	Up to 7 days of special leave that includes the birth of a child or miscarriage, among other contingencies	100 per cent of reference monthly earnings	No provisions identified
Indonesia	Employer liability	2 days with possibility of extension	100 per cent of reference monthly earnings	No provisions identified
Lao PDR	Employer liability	3 days of personal leave that includes the birth of a child or miscarriage, among other contingencies	100 per cent of reference earnings	No provisions identified
Malaysia	Employer liability	7 days	100 per cent of reference earnings	No provisions identified
Philippines	Employer liability	7 days	100 per cent of reference earnings	No provisions identified
Thailand	Employer liability	15 days	100 per cent of reference earnings	No provisions identified

Financing

Without adequate levels of financing sustained over time, social protection during maternity is subject to gaps in coverage and adequacy across both access to maternity care and income security. Robust and sustainable sources of public revenues channelled to social protection benefits in case of maternity are needed. In this respect, ASEAN Member States, while having made noteworthy efforts in recent decades, have reached different levels of public expenditure thereof.

It is worthwhile to mention the difficulty of consolidating and comparing data on public expenditure allocated to the different types of social protection benefits mentioned in previous sections of this report. Such benefits are seldom tracked in a disaggregated manner, and often only aggregated data can be found for the purpose of comparison over time and across countries. While this holds true, there is evidence that the overall level of public spending on health and social protection has an impact on maternal health outcomes (figure 13) (Lim et al. 2023; Singh et al. 2022).

► **Figure 13: General Government expenditure on health as a share of current health expenditure, maternal mortality ratio and share of women giving birth attended by skilled health personnel in ASEAN Member States, latest year available**



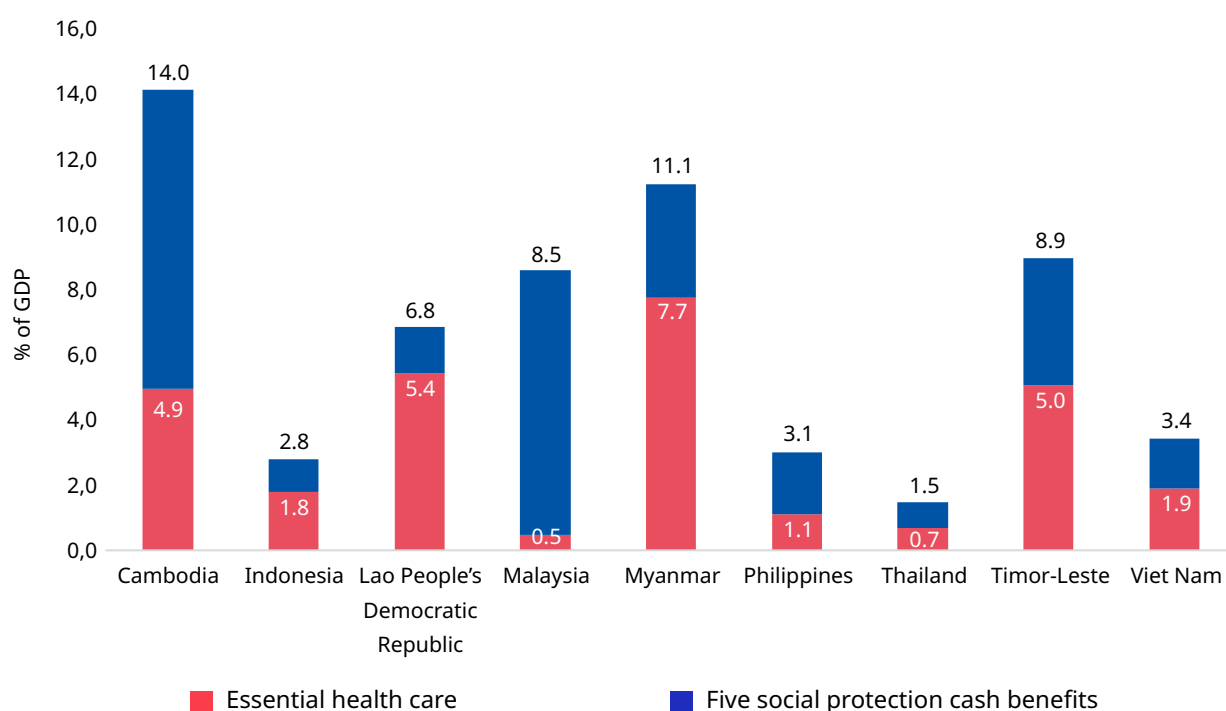
Source: Based on data from the WHO, Global Health Observatory.

Regarding expenditure on social protection cash benefits during maternity, there is a scarcity of published data. Many of the responsible institutions at the national level do not report their expenditure in a disaggregated manner. Tracking is particularly difficult for non-contributory cash transfers that include pregnant women and new mothers among a wider range of beneficiaries. However, an analysis of social protection expenditure for cash benefits disaggregated by broad age groups shows that only six ASEAN Member States report expenditure for population groups of working age, and in all of these countries, the level of expenditure is significantly lower than the global average, ranging from 0-3 per cent of GDP. This is in line with the gaps observed in coverage of maternity cash benefits.

In terms of public expenditure on RMNCH services, only three countries among ASEAN Member States report expenditure on reproductive health as a share of current health expenditure (CHE), out of which only two track domestic general government expenditure on reproductive health (Cambodia and Myanmar). In both countries, these expenditures represent less than one per cent of government expenditure.

There are two drivers behind this lack of financing for social protection during maternity, which themselves have deeper roots in the political economy governing public expenditure allocations. Firstly, there is generally a difficulty in finding fiscal space for social protection and health, particularly in countries that have a tax to GDP ratio lower than OECD countries, and where the size of the tax base is limited by a pervasive informal economy. Secondly, health and social protection, including benefits and services geared towards maternity and, more generally, the needs of women and children, tend not to be highly prioritized within government budgets. This results in a significant financing gap for health and social protection (figure 14), which in turn disproportionately affects benefits and services geared to women and children.

► **Figure 14: Financing gap for social protection**



Note: Social protection benefits include minimum floors of cash support in cases of unemployment, old age, maternity, disability and childhood. Global and regional aggregates are weighted by GDP. Data for Brunei Darussalam and Singapore are not available.

Source: Cattaneo et al. (2024)

► 4 Adopting integrated approaches

Key messages

- There is minimal literature available documenting the coordination and integration between social protection entitlements during maternity, or between these entitlements and wider policy areas. Such evidence would support the effective identification of mechanisms through which integrated approaches can be implemented, and the factors that facilitate or hinder such approaches.
- Several countries in the region aim to adopt integrated policy and legislative frameworks for services during maternity, which can support in enhancing coordination between stakeholders. Further evidence on the manner in which such frameworks effectively translate into coordinated or integrated approaches would be relevant to understanding their application in practice.
- Examples of coordination or integration within the design of schemes and at the administrative level are more widely documented in relation to non-contributory programmes than they are for contributory schemes, including in relation to the targeting of beneficiaries and beneficiary data management. More systematic documentation of coordination in relation to contributory schemes could support the identification of best practices, as well as related challenges.

As highlighted above, coherence and integration between social protection entitlements during maternity and wider social protection policies, as well as with complementary policy areas, is essential to ensuring comprehensive support to pregnant and lactating mothers and newborns, and their effective access to benefits and services.

This section does not represent a systematic review of integrations, but rather aims to provide examples from among ASEAN Member States of the types of integrations that have been identified through research. Integration and coherence can be identified across different dimensions, and the discussion below is structured around these dimensions.

Integration and coherence within policy, legislative and institutional frameworks

In several contexts in the region, there are integrated policies or legislative frameworks that aim to provide a comprehensive approach to the rights of parents and newborns before, during and after birth, often providing direction across range of policy areas.

In **Brunei Darussalam**, for example, a whole-of-society approach has been adopted by the Government under the National Strategy for Maternal, Infant and Young Child Nutrition (MIYCN) of 2014-2020 (Ministry of Health Brunei Darussalam 2014). The strategy links maternity protection measures with broader health and social policies, including the Maternity Leave Regulation of 2011 which extended statutory maternity leave from 56 to 105 days to support maternity recovery and enable exclusive breastfeeding (Ministry of Health Brunei Darussalam 2014; Government of Brunei Darussalam 2011). It also promotes workplace-based maternity protection measures, such as paid breastfeeding breaks, and the introduction of flexible working arrangements (Ministry of Health Brunei Darussalam 2014).

Several policy and strategic frameworks also exist in **the Philippines** to strengthen coherence and coordination between different policy areas in relation to maternity. Firstly, Administrative Order No. 2008-0029 aimed to formulate an integrated RMNCH strategy. The strategy outlines minimum standard services across the continuum of care, and also highlights PhilHealth's responsibility in increasing enrolment, assisting facilities in managing their claims, payments and reimbursements, and improving its benefit package. In this way, the strategy

aimed to promote coherence between the health system and the social health protection scheme. Secondly, coherence and coordination across a wider range of policy areas was mandated by the *Kalusugan at Nutrisyon ng Mag-Nanay* Act (RA 11148) in 2018, also known as the First 1,000 Days Law. It established a policy framework to scale up health and nutrition programmes for maternal, neonatal and child health and nutrition in the first 1,000 days of life through an integrated strategy. The Law mandates multisectoral action to strengthen health and nutrition services and interventions, including PhilHealth enrolment, social welfare support to improve access to health and nutrition services, maternity protection during pregnancy, and coverage and utilization of PhilHealth benefit packages for maternal care (Republic Act No. 11148 : *Kalusugan at Nutrisyon ng Mag-Nanay* Act 2018). Implementation of RA 11148 is coordinated by the Department of Health, in collaboration with the National Nutrition Council Governing Board.¹⁵

In **Indonesia**, a specific legislative instrument aims to cover the range of rights and entitlements of mothers and newborns in a comprehensive and coherent manner. Here, the Law No. 4 of 2024 on Maternal and Child Welfare During the First 1,000 Days of Life provides an integrated approach during this period, outlining the rights of workers to leave, as well as rights related to healthcare, childcare and so on. Through this approach, entitlements to a range of benefits – beyond social protection – are legislated in a coherent manner, with the objective of promoting comprehensive access to all relevant services.

As outlined in previous chapters, institutional arrangements have been adopted in certain contexts that may facilitate coherence between social protection entitlements during maternity, although unified administration is not necessarily a prerequisite for better integration. One example in this context is the case of the Central Provident Fund (CPF) in **Singapore**. The CPF is responsible for the administration and financial management of tax-financed social protection cash benefits (including the Government-Paid Maternity Leave, Paternity Leave, Shared Parental Leave, the Baby Bonus Scheme, and the Child Development Account), while also administering the MediSave Grant for Newborns, as well as the MediSave and MediShield Life schemes (Ministry of Health Singapore 2025; Government of Singapore 2001, 2015). Through this arrangement, the CPF system not only facilitates the disbursement of cash grants but also ensures continuity of social security contributions.

A level of institutional coherence is also promoted in **Malaysia**, where the Government has been strengthening integration between its national health system and broader social protection framework through enhanced institutional coordination under the Malaysian Social Protection Council (MySPC) (ILO 2021b). Serving as the central inter-agency platform, MySPC brings together the Ministry of Health (MOH), the Employees Provident Fund (EPF), and the Social Security Organisation (SOCSO) through its Technical Committee and specialized working committees, aiming to improve policy coherence and data interoperability across social protection schemes nationwide (ILO 2021b; Ministry of Economy Malaysia 2021).

Integration and coherence within the scheme or programmatic design

In some contexts, integration and coordination between schemes and policy areas is also evident within the design of the schemes themselves. This is often more visible in the context of non-contributory cash transfer programmes, in which the programmes include design features that aim to enhance access to RMNCH services, including in the form of conditionalities, or where coverage of social health protection is a benefit of inclusion in the programme. In the **Philippines**, all identified 4Ps beneficiaries are automatically enrolled and provided coverage under the Sponsored Programme Component of the NHIP, ensuring entitlement to all NHIP benefits, accessible in all healthcare providers accredited by PhilHealth (PhilHealth Circular No 2012-024 Entitlement to NHIP Benefits of All Pantawid Pamilyang Pilipino Program Beneficiaries of the DSWD 2012). Similarly, households covered by the Helping Hands cash transfer programme in **Lao PDR**, identified as “poor”, are automatically enrolled in the

¹⁵ The latter is composed of Secretaries from across the Department of Agriculture, the Department of the Interior and Local Government, the Department of Education, the Department of Social Welfare and Development, the Department of Trade and Industry, the Department of Labour and Employment, the Department of Science and Technology, the Department of Budget and Management and the Department of National Economic and Development Authority, as well as representatives from the private sector (Republic Act No. 11148 : *Kalusugan at Nutrisyon ng Mag-Nanay* Act 2018).

national health insurance scheme, with different entitlements compared with “non-poor” households in terms of co-payment rates and non-medical benefits applicable at point of use. Cash transfer programmes also often include conditionalities or “behavioural change education” components that aim to improve access to RMNCH services or influence health-seeking behaviours. For example, the PKH programme in **Indonesia** provides cash transfer payments conditional on compliance with maternal and child health requirements, such as regular prenatal visits and facility-based delivery (Syamsulhakim and Khadijah 2021). This conditionality mechanism effectively links income support with service utilization, although global evidence points to the care that is needed when adopting such approaches.

Beyond coordination within social protection schemes and with the health system, examples also exist of coordination with other areas of policy. The design of the *Bolsa da Mãe Kondisional ba Saúde Nutrisaun Inan no Oan* programme in **Timor-Leste**, for example, places a strong emphasis on the integration of nutrition and health interventions. Food distribution is carried out through centres designated by the MSSI, in coordination with the Ministry of Health and local health services. The associated financial incentive is disbursed quarterly at the time beneficiaries collect their food packages, thereby reinforcing linkages between income support, nutrition assistance and engagement with health services.

Fewer clear examples were identified in relation to contributory mechanisms, although certain countries do adopt measures to ensure coherence between policy areas. For example, cash benefits are provided by the NSSF in **Cambodia** for time off to receive antenatal and prenatal care, which promotes coherence between access to health services and income security by addressing any potential opportunity costs associated with accessing such care. More in-depth research would be required to identify how contributory mechanisms can or have promoted greater coherence and integration within and across policy areas.

Integration and coherence at the administrative level

Finally, efforts to promote greater coherence and integration within and between policy areas have been identified in administrative and operational practices adopted by the institutions that govern and administer social protection programmes during maternity. Efforts that were identified include the simplification of administrative procedures, the adoption of common beneficiary targeting mechanisms and registries across programmes, and efforts to streamline and share data between institutions and actors, which underpin some of the integration efforts highlighted above.

Efforts to simplify procedures have been adopted by the VSS in Viet Nam, where the Government has been prioritizing greater coherence across the social security system to deliver more integrated and efficient services. Here, the VSS has aimed to streamline registration processes by requiring a single dossier to be submitted for both social and health insurance. The VSS processes the dossier through a single-window system, verifying components, entering data into a common management programme, and coordinating the issuance of both the social insurance book and the health insurance card.¹⁶

In turn, some countries have been moving towards common beneficiary identification systems and beneficiary data management systems, and common identification across programmes and schemes, particularly in relation to non-contributory programmes targeted at vulnerable population groups. Such approaches can promote cost efficiency and support data exchange, while also facilitating administrative processes for recipients by granting access to multiple types of services through a single mechanism or identification card. In several cases, health facilities can also directly access information through these systems to check eligibility for services, promoting linkages between social protection and health services. For example:

16 <https://vss.gov.vn/english/administrative-procedures/Pages/default.aspx?ItemID=92>

- In Timor-Leste, the *Bolsa da Mãe Kondisional ba Saúde Nutrisaun Inan no Oan* programme has indicated plans to rely on a dedicated social registry. For this purpose, a specific social database is to be established and integrated into the national social protection system managed by the Ministry of Social Solidarity and Inclusion. The database is intended to capture beneficiary ID and residence information, socio-economic and nutritional status, compliance with monitoring requirements, as well as records of payments, food distributions and service utilization. Law No. 29/2025 explicitly mandates interoperability with civil registration, health and social assistance information systems, supporting coordinated service delivery and improved targeting.
- In Indonesia, government-financed premium subsidies for health insurance for vulnerable households are coordinated with other social assistance programmes through the *Data Terpadu Kesejahteraan Sosial* (DTKS), or Unified Data of Social Welfare, strengthening alignment in beneficiary identification and public financing (Barca 2017). The Unified Data of Social Welfare functions as a common targeting registry across ministries, while the use of the national identification number facilitates cross-programme verification and enrolment (Barca 2017).
- In Malaysia, integration has been advanced through the *Pangkalan Data Utama* (PADU) centralized database, a unified repository of individual and household socio-economic profiles (Ministry of Economy Malaysia 2025). PADU serves as a single reference point for eligibility verification across government programmes by consolidating administrative data from multiple agencies, including health, social welfare and social security institutions (Ministry of Economy Malaysia 2025). PADU enables streamlined access to targeted health and social protection benefits, including automatic eligibility checks for programmes such as PeKa B40 health screenings (Ministry of Economy Malaysia 2025, 2021). By consolidating beneficiary data, PADU reduces fragmentation and duplication, including multiple claims by the same individuals, and strengthens alignment between health services (Ministry of Economy Malaysia 2025).
- In the Philippines, eligibility verification and benefit access are operationalized through streamlined administrative systems. The unique Identification Card provided to 4P beneficiaries can be used to claim NHIP benefits. Healthcare providers can determine the eligibility of 4P beneficiaries under the NHIP through PhilHealth CARES Nurses, deployed in selected hospitals or via the Institutional Health Care Provider Portal which serves as a link between healthcare providers and PhilHealth (PhilHealth Circular No 2012-024 Entitlement to NHIP Benefits of All Pantawid Pamilyang Pilipino Program Beneficiaries of the DSWD 2012). There have been further efforts to strengthen the integration of social protection and healthcare through collaboration between regional PhilHealth offices and the Department of Social Welfare and Development offices to provide 4P beneficiaries with a PhilHealth identification card which facilitates access to healthcare services (Sibbaluca 2025).

Further research would be required to identify and understand how simplifications and reforms to administrative procedures – or the adoption of common mechanism across schemes – remove access barriers to relevant entitlements and facilitate coverage for users, especially pregnant and lactating women and newborns.



► 5 Conclusion and recommendations to strengthen income and health protection during maternity in ASEAN

This report has explored the current landscape of social protection during maternity across the ASEAN region, highlighting both significant progress and persistent challenges. While there is growing recognition of the importance of protecting mothers and newborns, findings suggest that substantial gaps remain between international standards and the realities of millions of women in the region.

The analysis highlights significant disparities in coverage and protection levels across the region in relation to income support, with significant differences across countries, but also within them, as women in informal employment, the self-employed and migrant workers are often excluded from social protection coverage. This is driven, in part, by operational challenges in reaching such groups, but also by the persistence of employer liability mechanisms that prevail in many contexts, which undermine effective access to necessary support.

In contrast, the region has seen more progress in relation to social health protection, with effective coverage for healthcare services reaching 80.5 per cent of the population, which is higher than the global average. However, this high level of coverage does not always translate into financial security. Achievements in relation to population coverage must therefore be combined with efforts to improve the adequacy of benefits provided, ensuring effective financial protection. Many countries continue to apply official co-payments for RMNCH services, which can act as a deterrent to seeking care or lead to catastrophic out-of-pocket expenditures for vulnerable households.

Furthermore, the misalignment between health protection and income support remains a critical issue; while a woman may have access to healthcare services, a lack of income support may force her to return to work prematurely, undermining the health benefits of the medical care she received. This misalignment results from a wide range of factors as outlined above, including financing mechanisms of the different benefits, institutional arrangements, and the socio-economic context.

To address these challenges and move towards universal and equitable systems of support during maternity, this report proposes several core policy recommendations:

- It is essential to consider needs during maternity **holistically** rather than as separate component parts, in recognition of the diversity of vulnerabilities faced during this period. This requires governments to legislate, administer and finance social protection during maternity in a coherent manner to ensure that all pregnant and lactating women and newborns have access to the range of complementary support that is needed. This report has aimed to provide examples of best practices in this regard, but more in-depth research would be needed to more systematically identify mechanisms for coordination and integration.
- Efforts to **extend coverage**, particularly to women in informal employment, the self-employed and migrant workers, must be redoubled to make progress towards universal social protection. This is essential to ensuring that pregnant and lactating women and their families are prevented from falling into poverty and vulnerability, and to guarantee their health and well-being. There are many positive examples from within the region of innovative approaches to extending coverage, both in relation to the financing and design of schemes, and also their implementation modalities. The lessons from these examples could inform policy and action in contexts in which systematic gaps persist. In particular, this requires moving beyond employer liability schemes or those based on voluntary enrolment, which typically see low uptake, towards mandatory and subsidized schemes that recognize the limited contributory capacity of low-income workers. As part of such efforts, adopting a gender equality lens is essential to ensure that measures take account of the realities and intersecting vulnerabilities faced by women.

- Achievements in relation to coverage must be combined with efforts to improve the **adequacy** of benefits provided, ensuring effective financial protection and adequate income support. Expanding effective coverage of schemes that are not adequate will ultimately limit the impacts of the schemes in terms of reducing poverty and vulnerability and supporting access to services. In relation to health protection, this means ensuring that RMNCH services are free at the point of use and that benefit packages are comprehensive. Coverage of transportation costs would also support in addressing some of the barriers to access. In relation to income support, it is necessary to increase the level and duration of benefits, and ensure their effective coordination with childcare policies. Greater efforts to strengthen coherence and harmonization of entitlements across schemes would also support efforts to promote equity among pregnant and lactating women and their families.
- To make progress the above areas, it is also essential to allocate adequate and sustainable **financing** for social protection during maternity, requiring evidence-based decision making, prioritizing social protection and maternity within national policy agendas, and innovative approaches to resource mobilization. However, investments in social protection alone are not sufficient; investments in the quality of RMNCH and wider health systems are critically important to translate population coverage of social health protection into improved health outcomes. In this context, it is essential to recognize investments in social protection and health as complementary rather competing priorities. Further investments in childcare are also essential to ensuring the continuity of support for families and promoting coherence between policy areas.
- Progress across the above dimensions would be facilitated through greater **exchange of knowledge** and experiences across the region. While substantive gaps persist, there are also positive examples of innovation in adopting more holistic approaches to maternity that promote coherent and universal coverage and adequacy. Knowledge exchange across the region that enables countries to learn from one another in relation to what does and does not work can support progress at the policy and operational level.

Strengthening social protection during maternity is a vital investment in the future of the ASEAN region. By closing gaps in coverage and adequacy, ASEAN Member States can promote social justice and health equity. The innovative practices already emerging in the region provide a foundation for knowledge exchange and collective progress towards a future where maternity is protected as a fundamental right for all.

Areas for future research/enhanced monitoring

The research for this report identified persistent gaps in data and evidence related to access to social protection for pregnant and lactating women, as well as outcomes in relation to poverty, vulnerability and health. Filling these gaps is essential in order to generate the evidence necessary to adopt tailored and realistic policy reforms. In particular, future research and monitoring efforts should prioritize the following:

- Disaggregated data on persons protected by health protection by sex, age and citizenship status should be systematically collected to understand the extent to which women giving birth and newborns have access to healthcare services without financial hardship.
- Better tracking of legal entitlements under social health protection schemes, including in relation to RMNCH, in a manner that enables comparability between benefit packages, would support a better understanding of the comprehensiveness and adequacy of benefits afforded.
- Data on out-of-pocket and catastrophic health spending on RMNCH would inform a better understanding of the coverage and adequacy of social health protection during maternity, as current data on these metrics are not disaggregated by type of services.
- In relation to income support, disaggregated data on the share of population covered by – and effectively accessing – income support during maternity could help to better identify where gaps persist and identify the profiles of excluded populations in order to adopt tailored approaches.

- Understanding working women's access to mechanisms that rely on employer liability, which remain prevalent in many contexts in ASEAN, would be important to understanding the effectiveness of such mechanisms in ensuring effective coverage and access.
- Systematic collection of data on legal and effective coverage rates of paternity and parental cash benefits, as well as any evidence on the barriers to uptake, should be promoted.
- Better tracking of social protection expenditure on maternity – both for healthcare benefits and income support – is also important to understand the adequacy of financing of these schemes.
- In-depth research on the mechanisms through which complementary policy areas are coordinated and integrated to better support pregnant and lactating women and their children would help to generate evidence on best practices; this should be combined with evidence on the political economy factors that drive these coordinated approaches and the extent to which these approaches facilitate access to a comprehensive range of services and support.

► References

- Abate, Biruk Beletew, Ashenafi Kibret Sendekie, Addis Wondimagegn Alamaw, et al. 2025. "Prevalence, Determinants, and Complications of Adolescent Pregnancy: An Umbrella Review of Systematic Reviews and Meta-Analyses." *AJOG Global Reports* 5 (1): 100441.
- Addati, Laura. 2015. "Extending Maternity Protection to All Women: Trends, Challenges and Opportunities." *International Social Security Review* 68 (1): 69–93. <https://doi.org/10.1111/issr.12060>.
- Addati, Laura, Naomi Cassirer, Katherine Gilchrist. 2014. *Maternity and Paternity at Work: Law and Practice Across the World*. International Labour Office. https://www.ilo.org/sites/default/files/wcmsp5/groups/public/%40dgreports/%40dcomm/%40publ/documents/publication/wcms_242615.pdf
- Addati, Laura, Umberto Cattaneo, and Emanuela Pozzan. 2022. *Care at Work: Investing in Care Leave and Services for a More Gender Equal World of Work*. International Labour Office. <https://www.ilo.org/publications/major-publications/care-work-investing-care-leave-and-services-more-gender-equal-world-work>.
- Ahmed, Shakil, M Mahmud Khan. 2011. "A maternal health voucher scheme: what have we learned from the demand-side financing scheme in Bangladesh?", *Health Policy and Planning*, 26(1), <https://doi.org/10.1093/heapol/czq015>
- Aitken, Zoe, Cameryn C. Garrett, Belinda Hewitt, Louise Keogh, Jane S. Hocking, and Anne M. Kavanagh. 2015. "The Maternal Health Outcomes of Paid Maternity Leave: A Systematic Review." *Social Science & Medicine* 130: 32–41.
- Alderman, Harold. 2015. *Leveraging Social Protection Programmes for Improved Nutrition: Summary of Evidence Prepared for the Global Forum on Nutrition-Sensitive Social Protection Programs*, 2015. World Bank. <https://documents1.worldbank.org/curated/en/462981467040874717/pdf/106265-PUB-REPLACEMENT-FILE-PUBLIC-K8701.pdf>
- Alhaji, Mohammed M., Sharbawi Roslin, Adrian Kay, and Nik AA Tuah. 2017. "Paid Maternity Leave Extension and Exclusive Breastfeeding Practice: Evidence from Brunei," *Asian Biomedicine* 11 (6): 435–42. <https://doi.org/10.1515/abm-2018-0020>.
- Amjad, Sana, Isaiah MacDonald, Thane Chambers, et al. 2019. "Social Determinants of Health and Adverse Maternal and Birth Outcomes in Adolescent Pregnancies: A Systematic Review and Meta-analysis." *Paediatric and Perinatal Epidemiology* 33 (1): 88–99.
- Angeles, Gustavo, Frank Otchere, Ramya Subrahmanian, Nyasha Tirivayi, Mathilde Van Drooghenbroeck, and Silke Staab. 2024. "Leveraging the Links: How Integrated Approaches Can Enhance the Transformative Potential of Social Protection for Women and Girls." *Insights from the 2024 World Survey Blog Series*. <https://socialprotection.org/discover/blog/leveraging-links-how-integrated-approaches-can-enhance-transformative-potential-social>.
- Barca, Valentina. 2017. *Integrating Data and Information Management for Social Protection: Social Registries and Integrated Beneficiary Registries*. Canberra: Commonwealth of Australia, Department of Foreign Affairs and Trade. <https://www.dfat.gov.au/sites/default/files/integrating-data-information-management-social-protection-full.pdf>.
- Bergthaller, Martina, and Lou Tessier. 2025. "Universal Health Insurance Schemes: A Comparative Analysis of Implementation Features in 10 Low- and Middle-Income Countries", ILO Working Paper No. 156. <https://doi.org/10.54394/PLHO1306>.

- Black, Robert, Ramanan Laxminarayan, Marleen Temmerman, Neff Walker (eds). 2016. *Reproductive, Maternal, Newborn, and Child Health: Disease Control Priorities, Third Edition (Volume 2)*, Washington (DC): The International Bank for Reconstruction and Development / The World Bank;
- Central Statistical Organization of the Republic of the Union of Myanmar. 2020. *Household Vulnerability Survey (HVS) Key Findings: Rapid Assessment of the Economic Impact of COVID-19 Restrictions on Vulnerable Households. December 2020*.
- Cookson, Tara Patricia, Nina Ebner, Yardain Amron, and Kritika Kukreja. 2023. "Social Protection Systems and Gender: A Review of the Evidence." *Global Social Policy*, June 20, 14680181231180507. <https://doi.org/10.1177/14680181231180507>.
- Dodzi Nyadanu, Sylvester, Jennifer Dunne, Gazichew Tessema, Ben Mullins, Bernard Kumi-Boateng, Michelle Belle, Bereket Duko, Gavin Pereira. 2024. "Maternal exposure to ambient air temperature and adverse birth outcomes: An umbrella review of systematic reviews and meta-analyses", *Science of the Total Environment*, 20(917), doi: 10.1016/j.scitotenv.2024.170236
- FAO [Food and Agriculture Organization of the United Nations], IFAD [International Fund for Agricultural Development], UNICEF [United Nations Children's Fund], WFP [World Food Programme], and WHO [World Health Organization]. 2024. *The State of Food Security and Nutrition in the World 2024: Financing to End Hunger, Food Insecurity and Malnutrition in All Its Forms*. <https://doi.org/10.4060/cd1254en>.
- Feng, Yikai, Mailikezhati Maimaitiming, Junyi Shi, et al. 2023. "Inequity of Maternal-Child Health Services in ASEAN Member States from 1993 to 2021." *International Journal for Equity in Health* 22: 1–10. <https://doi.org/10.1186/s12939-023-01974-8>.
- Folbre, Nancy. 2021. "The International Labour Review and gender equality: the importance of women's unpaid and paid work : introduction", *International Labour Review*, 3, doi: <https://doi.org/10.1111/ilr.12342>
- Frota, Luis, Lou Tessier, Christian Pflleiderer, and Zhao Ying. 2020. *Technical Note: International Review of Financial Protection in Maternal Health Care*. ILO Regional Office for Asia and Pacific. https://www.ilo.org/wcmsp5/groups/public/---asia/---ro-bangkok/---ilo-beijing/documents/briefingnote/wcms_765077.pdf.
- Government of Brunei Darussalam. 2011. *Peraturan Cuti Beranak 2011: Bagi Rakyat Dan Penduduk Tetap Yang Berkhidmat Di Sektor Swasta*. <https://www.labour.gov.bn/Download/Booklet%20Peraturan%20Cuti%20Beraanak%202011.pdf>.
- Government of Singapore. 2001. *Central Provident Fund (Medisave Account Withdrawals) Regulations 2001* [2025 Revised Version]. <https://sso.agc.gov.sg/SL/CPFA1953-RG17>.
- Government of Singapore. 2015. *MediShield Life Scheme Act 2015*. [2020 Revised Version]. <https://sso.agc.gov.sg/Act/MLSA2015>.
- Hatt, L.E, M. Makinen, S. Madhavan, and C.M.. 2013. "Effects of User Fee Exemptions on the Provision and Use of Maternal Health Services: A Review of Literature." *Journal of Health, Population and Nutrition*. <https://pubmed.ncbi.nlm.nih.gov/articles/PMC4021702/#:~:text=User%20fees%20exempted%20or%20reduced,among%20pregnant%20women%20and%20newborns>.
- Hernández-Cordero, Sonia, Rafael Pérez-Escamilla, Paul Zambrano, Isabelle Michaud-Létourneau, Vania Lara-Mejía, and Bianca Franco-Lares. 2022. "Countries' Experiences Scaling up National Breastfeeding, Protection, Promotion and Support Programmes: Comparative Case Studies Analysis." *Maternal and Child Nutrition*, Suppl. S3: 2915068478. <https://doi.org/10.1111/mcn.13358>.
- Herwansyah, Herwansyah, Katarzyna Czabanowska, Stavroula Kalaitzi, and Peter Schröder-Bäck. 2022. "The Utilization of Maternal Health Services at Primary Healthcare Setting in Southeast Asian Countries: A Systematic Review of the Literature." *Sexual & Reproductive Healthcare* 32: 100726. <https://doi.org/10.1016/j.srhc.2022.100726>.

- Hong, Seo Ah, and Doungjai Buntup. 2023. "Maternal Depression during Pregnancy and Postpartum Period among the Association of Southeast Asian Nations (ASEAN) Countries: A Scoping Review." *International Journal of Environmental Research and Public Health* 20 (6): 5023.
- Hunter, Benjamin, Susan Murray. 2017. "Demand-side financing for maternal and newborn health: what do we know about factors that affect implementation of cash transfers and voucher programmes?" *BMC Pregnancy Childbirth*, 17(1), doi: 10.1186/s12884-017-1445-y.
- ILO [International Labour Organization]. 2016. *Maternity Cash Benefits for Workers in the Informal Economy*. Social Protection Spotlight. <http://www.social-protection.org/gimi/gess/RessourcePDF.action?ressource.ressourceId=54094>.
- _____. 2020. *Towards Universal Health Coverage: Social Health Protection Principles*. Social Protection Spotlight. <https://www.social-protection.org/gimi/RessourcePDF.action?id=56009>.
- _____. 2021a. *Extending Social Health Protection: Accelerating Progress towards Universal Health Coverage in Asia and the Pacific*. <https://www.social-protection.org/gimi/ShowRessource.action?id=38425>.
- _____. 2021b. *Extending Social Security to Workers in the Informal Economy: Lessons from International Experience*. <https://www.social-protection.org/gimi/Media.action?id=16990>.
- _____. 2024a. *World Social Protection Report 2024-26: Universal Social Protection for Climate Action and a Just Transition*. <https://researchrepository.ilo.org/esploro/outputs/report/995382292502676>.
- _____. 2024b. *Extending Social Health Protection: Accelerating Progress towards Universal Health Coverage in Central and Western Asia*. <https://www.social-protection.org/gimi/ShowRessource.action?id=58650>.
- _____. 2024c. *Securing Access to Long-Term Care without Hardship as an Integral Part of Universal Social Protection Systems*. *Social Protection Spotlight*. <https://www.social-protection.org/gimi/Media.action?id=19700>.
- _____. 2024d. *Universal Social Protection for All Carers: A Necessity for Securing Long-Term Care in the Context of Population Ageing*. Social Protection Spotlight. <https://www.social-protection.org/gimi/Media.action?id=19818>.
- _____. 2024e. "Resolution and Conclusions Concerning Decent Work and the Care Economy, Adopted by the International Labour Conference, 112th Session (ILC.112/Resolution V)." <https://www.ilo.org/resource/record-decisions/resolution-concerning-decent-work-and-care-economy>.
- _____. 2024f. *The Impact of Care Responsibilities on Women's Labour Force Participation*. https://www.ilo.org/sites/default/files/2024-10/GEDI-STAT%20brief_formatted_28.10.24_final.pdf.
- _____. 2025. *Fostering Inclusion: Advancing Social Health Protection for Persons with Disabilities in Cambodia, the Lao People's Democratic Republic and Viet Nam*. https://www.ilo.org/sites/default/files/2025-01/Final%20ILO_SHP_disability_4.pdf.
- _____. 2026a. *Proteccion Social en Salud en America Latina: Hacia la Cobertura Universal*. www.ilo.org/es/publications/proteccion-social-en-salud-en-america-latina-hacia-la-cobertura-universal.
- _____. 2026b. *Social Health Protection for Gender Equality*. https://www.ilo.org/sites/default/files/2026-03/ILO%20brief_Social%20health%20protection%20for%20gender%20equality.pdf.
- _____. n.d. *Social Insurance Reforms for Maternity and Paternity Benefits in Oman*. <https://webapps.ilo.org/globalcare/south-4-care/7?language=en>.
- ILO and ADB [Asian Development Bank]. 2023a. *Where Women Work in Asia and the Pacific- Implications for Policies, Equity and Inclusive Growth*. <https://www.adb.org/sites/default/files/publication/916051/where-women-work-asia-pacific.pdf>.
- _____. 2023b. *Investments in Childcare for Gender Equality in Asia and the Pacific*. https://www.ilo.org/sites/default/files/wcmsp5/groups/public/%40asia/%40ro-bangkok/documents/publication/wcms_887517.pdf.

- ILO and FAO. 2021. *Extending Social Protection to Rural Populations: Perspectives for a Common FAO and ILO Approach*. <https://www.social-protection.org/gimi/RessourcePDF.action?id=57189>.
- ILO and NHIF. 2023. *The Introduction of a Maternity Cash Benefit in Kenya*. <https://www.social-protection.org/gimi/Media.action?id=19365>.
- ILO and UNICEF. 2023. *More than a Billion Reasons: The Urgent Need to Build Universal Social Protection for Children*. https://www.ilo.org/sites/default/files/wcmsp5/groups/public/%40ed_protect/%40soc_sec/documents/publication/wcms_869602.pdf.
- Jehan, Kate, Kristi Sidney, Helen Smith, Ayesha de Costad. 2021. "Improving access to maternity services: an overview of cash transfer and voucher schemes in South", *Reproductive Health Matters*, 20(39), doi: 10.1016/S0968-8080(12)39609-2.
- Jou, Judy, Katy B. Kozhimannil, Jean M. Abraham, Lynn A. Blewett, and Patricia M. McGovern. 2018. "Paid Maternity Leave in the United States: Associations with Maternal and Infant Health." *Maternal and Child Health Journal*, 22 (2): 216–25. <https://doi.org/10.1007/s10995-017-2393-x>.
- Lao Statistics Bureau and UNICEF. 2023. *Lao Social Indicator Survey III 2023 - Survey Findings Report*. Vientiane. https://nipn.lsb.gov.la/wp-content/uploads/2025/02/LSIS-III-2023-SFR-Eng-13-02-2025-V_6_7-for-web-Bookmark.pdf.pdf.
- Liabsuetrakul, Tippawan. 2022. "Disparities in Universal Health Coverage for Maternal and Newborn Care in Ethnic Minorities in South-East Asia", *WHO South-East Asia Journal of Public Health*, 11 (1): 1- 2. <https://pubmed.ncbi.nlm.nih.gov/36308266/>.
- Lim, Ming Yao, Hanin Farhana Kamaruzaman, Olivia Wu, and Claudia Geue. 2023. "Health Financing Challenges in Southeast Asian Countries for Universal Health Coverage: A Systematic Review." *Archives of Public Health* 81 (1): 148.
- Maramag, Cherry C., Jyn Allec R. Samaniego, Mary Christine Castro, et al. 2023. "Maternity Protection Policies and the Enabling Environment for Breastfeeding in the Philippines: A Qualitative Study." *International Breastfeeding Journal* 18: 1–14. <https://doi.org/10.1186/s13006-023-00594-w>.
- Memirie et al. 2019. "A Cost-Effectiveness Analysis of Maternal and Neonatal Health Interventions in Ethiopia." *Health Policy and Planning* 34 (4): 289–97. <https://doi.org/https://doi.org/10.1093/heapol/czz034>.
- Merttens, Fred, Chansathith Chaleunsinh, Wajid Habib, Paul Jasper, Umer Naeem, and Revita Wahyudi. 2024. *Understanding Informality and Expanding Social Security Coverage in the Lao People's Democratic Republic*. ILO. <https://researchrepository.ilo.org/esploro/outputs/report/Understanding-informality-and-expanding-social-security/995358690302676>.
- Ministry of Economy Malaysia. 2021. *Twelfth Malaysia Plann 2021-2025: A Prosperous, Inclusive, Sustainable Malaysia*. <https://rmke12.ekonomi.gov.my/en>.
- Ministry of Economy Malaysia. 2025. *Thirteenth Malaysia Plan 2026-2030: Melakar Semula Pembangunan*. <https://www.investmalaysia.gov.my/media/m3eamxey/thirteenth-malaysia-plan-2026-2030.pdf>.
- Ministry of Health Brunei Darussalam. 2014. *National Strategy for Maternal, Infant and Young Child Nutrition (MIYCN) in Brunei Darussalam 2014-2020*. <https://platform.who.int/docs/default-source/mca-documents/policy-documents/plan-strategy/BRN-CC-10-01-PLAN-STRATEGY-eng-National-Strategy-MIYCN-2014-2020.pdf>.
- Ministry of Health of the Republic of Indonesia. 2025. *Indonesia Health Profile 2024*. <https://kemkes.go.id/eng/indonesia-health-profile-2024>.
- Ministry of Health Singapore. 2025. "MediShield Life." February 20. <https://www.moh.gov.sg/managing-expenses/schemes-and-subsidies/medishield-life/medishield-life/>.

- Ministry of Social and Family Development of the Republic of Singapore. 2025. *Family Trends Report 2025*. https://www.msf.gov.sg/docs/default-source/research-data/family-trends-report-2025.pdf?sfvrsn=1aa1782d_3.
- Nagpal, Somil, Emiko Masaki, Eko Setyo Pambudi, and Bart Jacobs. 2019. "Financial Protection and Equity of Access to Health Services with the Free Maternal and Child Health Initiative in Lao PDR." *Health Policy and Planning* 34 (Supplement 1): 14–25.
- Noor, Nazihah Muhamad, Puteri Marjan Megat Muzafar, and Jarud Romadan Khalidi. 2020. *Health of the Nation: Measuring Burden of Disease*. Khazanah Research Institute. http://www.krinstitute.org/Working_Paper-@-Health_of_the_Nation-;_Measuring_Burden_of_Disease.aspx.
- Pathmanathan, Indra, Jerker Liljestrand, Jo Martins, et al. 2003. *Investing in Maternal Health: Learning from Malaysia and Sri Lanka*. World Bank. <https://openknowledge.worldbank.org/handle/10986/14754>.
- Perera, Camila, Shivit Bakrania, Alessandra Ipince, et al. 2022. "Impact of Social Protection on Gender Equality in Low- and Middle-Income Countries: A Systematic Review of Reviews." *Campbell Systematic Reviews* 18 (2): e1240. <https://doi.org/10.1002/cl2.1240>.
- Razavi, Shahra, Ian Orton, Christina Behrendt, et al. 2024. "Making Social Protection Work for Gender Equality: What Does It Look like? How Do We Get There?", ILO Working Paper No. 132. <https://www.ilo.org/publications/making-social-protection-work-gender-equality-what-does-it-look-how-do-we>.
- Segal, Thalia, Linda Guidice. 2023. "Systematic review of climate change effects on reproductive health", *Fertility and Sterility*, 118(2), doi: 10.1016/j.fertnstert.2022.06.005
- Sibbaluca, Mitchie Grace. 2025. "PhilHealth and DSWD FO2 Partner to Provide PhilHealth IDs to 4Ps Beneficiaries." DSWD, 16 July 2025. <https://fo2.dswd.gov.ph/2025/07/philhealth-and-dswd-fo2-partner-to-provide-philhealth-ids-to-4ps-beneficiaries/>.
- Singh, Shailender, Muhammad Muazu Bala, and Nishant Kumar. 2022. "The Dynamics of Public and Private Health Expenditure on Health Outcomes in Southeast Asia." *Health & Social Care in the Community* 30 (5): e2549–58.
- Sitkulanan, Piyaporn, Kunnikar Chaisitsanguan, Prakaipetch Winaiprasert, and Wilailuck Wong-arsa. 2024. "Problems of Myanmar Women of Reproductive Age in Accessing Health Services as Migrant Workers in Thailand: A Qualitative Study." *Nurse Media Journal of Nursing* 14 (1):53-64. <https://doi.org/10.14710/nmjn.v14i1.57287>.
- Stevens, Briony, Petra Buettner, Kerriane Watt, Alan Clough, Julie Brimblecombe, and Jenni Judd. 2015. "The Effect of Balanced Protein Energy Supplementation in Undernourished Pregnant Women and Child Physical Growth in Low- and Middle-Income Countries: A Systematic Review and Meta-Analysis." *Maternal & Child Nutrition* 11 (4): 415–32. <https://doi.org/10.1111/mcn.12183>.
- Sultana N, A. Hossain, H. Das, S. Pallikadavath, M. Koeryaman, M. Rahman, A.H. Chowdhury, A. Bhuiya, S.S. Mahmood, S.M.A Hanifi. 2023. "Is the maternal health voucher scheme associated with increasing routine immunization coverage? Experience from Bangladesh". *Front Public Health*, 2(11), doi: 10.3389/fpubh.2023.963162.
- Syamsulhakim, Ekki, and Nurzanty Khadijah. 2021. *Graduating from a Conditional Cash Transfer Program in Indonesia: Results of a Household Survey of Prosperous-Independent Graduates of the Family Hope Program (PKH) in 2020*. World Bank.
- Tessier, Lou. 2015. *Social Protection Assessment Based National Dialogue: Towards a Nationally Defined Social Protection Floor in Myanmar*. ILO. <http://www.social-protection.org/gimi/gess/RessourcePDF.action?ressource.ressourceId=52460>.

- UN [United Nations], ILO, and Ministry of Social Solidarity of Timor-Leste. 2018. *Challenges and Ways Forward to Extend Social Protection to All in Timor-Leste. Assessment-Based National Dialogue Report*. https://www.ilo.org/sites/default/files/wcmsp5/groups/public/%40asia/%40ro-bangkok/%40ilo-jakarta/documents/publication/wcms_638103.pdf.
- UNFPA [United Nations Population Fund]. 2021. *My Body Is My Own: State of World Population Report 2021*. https://asiapacific.unfpa.org/sites/default/files/pub-pdf/sowp2021_report_-_en_web.3.21_0_0.pdf.
- _____. 2025. *State of Asia's Midwifery 2024 Report Assessing Progress, Celebrating Success*. UNFPA. <https://asiapacific.unfpa.org/sites/default/files/pub-pdf/2025-08/AP%20midwifery%20report%20UNFPA%20final%20310725.pdf>.
- WHO [World Health Organization]. 2009. *Women and Health: Today's Evidence: Tomorrow's Agenda*. Geneva. <https://screening.iarc.fr/doc/Womenandhealthreport.pdf>.
- _____. 2016. *WHO Recommendations on Antenatal Care for a Positive Pregnancy Experience*. Guidelines. <https://www.who.int/publications/i/item/9789241549912>.
- _____. 2022. *WHO Recommendations on Maternal and Newborn Care for a Positive Postnatal Experience*. Guidelines. <https://www.who.int/publications/i/item/9789240045989>.
- _____. n.d. "Maternal, Newborn, Child and Adolescent Health and Ageing Data Portal." Accessed 1 April 2026. <https://platform.who.int/data/maternal-newborn-child-adolescent-ageing/national-policies>.
- WHO, UNICEF and UNFPA. 2023. *Trends in maternal mortality 2000 to 2023: estimates by WHO, UNICEF, UNFPA, World Bank Group and UNDESA/Population Division*, <https://www.who.int/publications/i/item/9789240108462>
- WHO and World Bank. 2023. *Tracking Universal Health Coverage: 2023 Global Monitoring Report*. <https://www.who.int/publications/i/item/9789240080379>.
- World Bank. 2020. "World Bank Open Data." Accessed 20.04.2026. <https://data.worldbank.org/>.
- Yang, Xiali, Xin Wee Chen, and Philip RA Baker. 2025. "Defining High-Risk Pregnancy: Protocol for a Systematic Scoping Review of Clinical Determinants, Complications, and Adverse Birth Outcomes." *PLoS One* 20 (10): e0334326.



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